



Debbie Wells
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February 8, 2010

Dear Parent(s)/Guardian(s),

You are receiving this packet on behalf of the Waukesha School District to provide you with information regarding “*Future 4 Waukesha*” 4 year old Kindergarten. “*Future 4 Waukesha*” is a free half day public school program designed to prepare four year olds for school success. An abundance of research supports the value of four-year-old Kindergarten for children’s optimal transition to Kindergarten and their sustained academic success in the school years.

“*Future 4 Waukesha*” is a collaborative community approach where programming is conducted in a variety of locations throughout the Waukesha School District. Each of the sites has a Wisconsin Department of Public Instruction (DPI) licensed Kindergarten teacher assigned to teach the “*Future 4 Waukesha*” 4K class(es). Families are encouraged to visit and tour sites prior to the March 13 registration date.

Numerous sites provide wrap around or extended care in order to provide a full day of care. If wrap around care is needed, it is the parent/guardian’s responsibility to make those arrangements separately with the sites. Parent(s)/Guardian(s) will be responsible for the cost of wrap around care.

Enclosed are the registration materials necessary for applying to the “*Future 4 Waukesha*” Program for the 2010 – 2011 school year. In order to enroll your child, you are required to complete all attached forms and bring them with you to registration. A parent or guardian **MUST** be present to enroll a 4 year old; no proxy registrations will be accepted. Children will not be registered until **ALL** paperwork is complete. Final placement will not occur until the child’s residence and age are verified and the attached paperwork is turned in.

Registration for 4K will be held on Saturday, March 13 from 9:00 – 11:00 AM at Central Middle School in the Large Gymnasium and Cafeteria located at 400 N. Grand Ave., Waukesha WI 53186. Children are encouraged not to attend the registration. All School District of Waukesha resident 4 year olds are entitled to a placement in a 4K program. We will make every effort to place your child in one of your top three choices.

For further questions, please feel free to contact me at (262) 970 – 1143 or dwells@waukesha.k12.wi.us. We look forward to seeing you at registration.

Sincerely,

Debbie Wells
4K and Kindergarten Coordinator

Please bring ALL items below to Registration

Important: Complete all paperwork prior to your attendance at registration March 13.

- Child’s Birth Certificate
- Parent/Guardian Picture ID
- Proof of Residence (*current utility bill or signed lease*)
- Self addressed, stamped envelope
- Day Care Immunization Record (*enclosed*)
- Health History and Emergency Care Plan (*enclosed*)
- Home Language Survey (*enclosed*)
- Technology Acceptable Use Form (*enclosed*)
- School District Census Form (*enclosed*)
- Site Selection Form (*enclosed*)



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ENROLLMENT FORM

School District of Waukesha

4 year old Kindergarten

STUDENT INFORMATION

Legal Name - First		Middle	Last		Birth date	Gender
Street Address		Number	City		State	Zip Code
Home Phone		Birthplace - City, State, Country			Student's Ethnic Origin	
Resident of Waukesha District 0 Yes 0 No If no, what district		What language(s) does your child speak?			What is the primary language at home? (if not English, complete Home Language Survey)	
Does your child have a chronic illness or disability? 0 Yes 0 No		Does your child take any medication? 0 Yes 0 No				
Asthma 0 Yes 0 No	Seizures 0 Yes 0 No	list-				
Cardiac 0 Yes 0 No	Diabetes 0 Yes 0 No					
Other - 0 Yes 0 No	Allergies 0 Yes 0 No					
list-		list-			Will your child require medication during the day? 0 Yes 0 No	
		If yes, complete a "Authorization to Administer Medication" Form				

FAMILY INFORMATION - Student Residence #1

Relationship	First Name	MI	Last Name	Place of Employment	Work Phone (with ext.)
				E-mail Address	Cell Phone
Relationship	First Name	MI	Last Name	Place of Employment	Work Phone (with ext.)
				E-mail Address	Cell Phone

FAMILY INFORMATION - Student Residence #2

Relationship	First Name	MI	Last Name	Place of Employment	Work Phone (with ext.)
				E-mail Address	Cell Phone
Relationship	First Name	MI	Last Name	Place of Employment	Work Phone (with ext.)
				E-mail Address	Cell Phone
Street Address		Number	City	State	Zip Code
Home Phone					

*School district "must give full rights with regard to pupil records to either parent, unless there is a court order or other legally binding document relating to divorce, separation or custody that specifically revokes these rights." (Students Record and Confidentiality bulletin, WI DPI August 2006).
For school personnel only - 0 Custodial parent documentation has been collected and is on file.

****PLEASE COMPLETE OTHER SIDE****

PREVIOUS SCHOOL ATTENDED

School Name	Address	Did your child receive Special Education
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		services at previous school? 0 Yes 0 No
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SIBLINGS				
First & Last Name	School, if applicable	First & Last Name	School, if applicable	Additional sheets may be attached.

EMERGENCY CONTACT/AUTHORIZED PICK UP				
These people will be called and may have to pick up if a parent can not be reached.				
Full Name	Relationship	Home Phone	Cell Phone	Work Phone (with ext.)

CHILD FIND: If you have concerns regarding **ANY CHILD** in your home with regard to their functioning in any of the following areas, please check, and list their name(s):

_____ 0 Speech 0 Hearing 0 Vision 0 Learning 0 Behavior

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to exercise reasonable judgment with reference to transporting my child to Waukesha Memorial Hospital or another health care facility to obtain emergency care.

Parent/Guardian Signature _____ **Date** _____

Does your child need extended care? 0 Yes 0 No
 NOTE: Extended Care is available at some sites - it is the parents responsibility to make extended care arrangements. School building sites will not provide extended care.

For office use only

Student ID Number _____ SDW School Attendance Code _____

4K School Location _____

School District Census Information

Information about each child in the family (age 0-20 years)

Parent's names: _____

Name of student being registered on this form: _____

Address: _____

Phone: _____

Is there any language other than English spoken at home? No _____ Yes _____ Which? _____

	First Name	Middle Initial	Last Name (if different)	Date of Birth	Grade	Sex	School Code	Ethnic Code	Disability Code
1.	_____	_____	_____	___/___/___	___	___	___	___	___
2.	_____	_____	_____	___/___/___	___	___	___	___	___
3.	_____	_____	_____	___/___/___	___	___	___	___	___
4.	_____	_____	_____	___/___/___	___	___	___	___	___
5.	_____	_____	_____	___/___/___	___	___	___	___	___
6.	_____	_____	_____	___/___/___	___	___	___	___	___

Ethnic Codes: AI – American Indian / Alaskan Native AP – Asian or Pacific Islander
 B – Black, not Hispanic H – Hispanic W – White, not Hispanic

Disability Codes: (Condition is suspected or has been identified)

CD Cognitively Disabled	MH Multihandicapped	OT Health Impaired
LD Learning Disabled	OI Orthopedically Imp.	(Allergies, etc.)
ED Emotionally Disabled	SL Speech/Language Imp.	QU May have a disability.
HI Hearing Impaired	DB Deaf-Blind	Please arrange for consultation
VH Visually Handicapped		

Have you ever moved with your child for seasonal or temporary employment for agricultural or fishing activities such as crop work, cannery work, or nursery work which resulted in change of school district? **Yes / No**

Census Information Codes

Child's Name: List all children ages 0-20 residing at your address. List last names if different from parent's.

Child's Date of Birth: Enter the month (01-12) then the day (01-31) then the year (i.e.; 1986 would be 86):

SCHOOL CODES

01	Banting	06	Heyer	12	Prairie	16	White Rock
02	Bethesda	07	Hillcrest	13	Randall	17	Whittier
03	Blair	08	Lowell	14	Rose Glen		
04	Hadfield	09	Meadowbrook	15	Saratoga	27	Harvey Phillips
05	Hawthorne	11	Pleasant Hill	18	Summit View	28	Recovery School
21	Butler M.S.	23	Horning M.S.	24	North High	26	West High
22	Central M.S.			25	South High		
30	Academy for Basic Education			42	St. Joseph Middle School		
41	Beautiful Savior Lutheran			43	St. Luke's School		
37	Brookfield Christian School			45	St. Mary Grade School		
31	Catholic Memorial High School			46	St. Paul's School		
32	Christ the Lord			47	St. William Grade School		
36	Elm Grove Lutheran			66	Trinity Academy		
61	Heritage Christian			48	Trinity Lutheran School		
65	Montessori School of Waukesha			49	University Lake School		
38	Mt. Calvary Lutheran School			50	Waukesha Christian Academy		
62	Prairie Hill Waldorf School			33	West Suburban Christian Academy		
39	St. Anthony's School			52	Wisconsin Lutheran High School		
40	St. John Vianney School			54	University, College, Tech, or other Post HS		
55	Any school not mentioned above			59	Tuition Pd Milwaukee		
57	Tuition Pd. Elmbrook			63	Tuition Pd CESA 1		
58	Tuition Pd New Berlin			60	Home Teaching		

**Distrito Escolar de Waukesha
Encuesta de Idiomas**

El Distrito escolar de Waukesha está interesado en proveer programas especiales para todos aquellos estudiantes que hablen más de un idioma y que estén interesados en estos programas. Para establecer estos programas, es necesario saber si fuera de la escuela, por ejemplo en la casa o en la calle, se habla otro idioma fuera del inglés. De antemano le agradezco si contesta las siguientes preguntas:

Nombre del Estudiante: _____ Fecha de Nacimiento: _____

Escuela: _____ Grado: _____

Nombre del padre: _____ Descendencia: _____

Nombre de la madre: _____ Descendencia: _____

Preguntas para los Padres

1. ¿Habla usted otro idioma fuera del Inglés? Sí _____ No _____

¿Qué idioma? _____

2. ¿Lo practica usted con su familia? Sí _____ No _____

3. ¿Qué idioma aprendió su hijo a hablar primero? _____

Preguntas para el Estudiante

1. ¿Hablas o entiendes otro idioma fuera del inglés? Sí _____ No _____

¿Qué idioma? _____

2. ¿Que idioma hablas con tus padres?

(1) _____ (2) _____

3. ¿Que idioma hablas con tus amigos?

(1) _____ (2) _____

Firma del Padre/Encargado

Firma del Estudiante (si es mayor de 18)

Fecha

**Waukesha School District
Home Language Survey**

The School District of Waukesha is interested in providing instructional programs for all students who speak more than one language, and who would be interested in such a program. Information about the language background of each student is necessary to determine the need for programs. Your cooperation in providing the following information will be appreciated.

Student's Name: _____ Date of Birth: _____

School : _____ Grade: _____

Father's Name: _____ Ancestry: _____

Mother's Name: _____ Ancestry: _____

Parents, answer the following questions:

1. Do you speak a language other than English? Yes _____ No _____
If yes, what language? _____
2. Is that language other than English spoken at home? Yes _____ No _____
3. What language did your child learn first when he/she began to talk? _____

Students, answer the following questions:

1. Do you speak a language other than English? Yes _____ No _____
If yes, what language? _____
2. What language, or languages, do you use when talking to your parents?
(1) _____ (2) _____
3. What language, or languages, do you speak when talking to your friends?
(1) _____ (2) _____

Parent's Signature

Student's Signature (if over 18)

Date

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
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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.

<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to allow my child to self-apply sunscreen.		
<input type="checkbox"/> Yes <input type="checkbox"/> No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> No specific medical condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gastrointestinal or feeding concerns including special diet and supplements
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy / seizure disorder	<input type="checkbox"/> Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
<input type="checkbox"/> Cerebral palsy / motor disorder		
<input type="checkbox"/> 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: _____

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 <i>Influenzae</i> 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

¹If 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).
²If 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.
³MMR 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).
⁴Children 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

Technology Acceptable Use

Please complete and sign this form.

I give my approval to have my child pictures used for school purposes.

School: _____

Child: _____

Parent/Guardian Signature _____

Date _____

Site Selection

Please complete this form by ranking 1 – 15 your order of preferences for attending 4 year old Kindergarten, with 1 being your top choice.

___ All About Learning

___ Child & Family Centers of Excellence, Inc.

___ Children's Educare/Mary Linsmeier Schools/Waukesha Memorial Hospital

___ Hadfield Elementary School Resident School ___ Yes ___ No ___ Unknown

___ Kindergarten Preparatory Preschool

___ La Casa de Esperanza

___ La Petite Academy

___ Lutheran Social Services Childcare

___ Montessori School of Waukesha

___ National Centers of Learning Excellence (Head Start)

___ Rose Glen Elementary School Resident School ___ Yes ___ No ___ Unknown

___ Summit View Elementary School Resident School ___ Yes ___ No ___ Unknown

___ St. Luke's Child Life Ministries

___ Waukesha Family YMCA

___ Waukesha Parks, Recreation and Forestry – Fox Tale Preschool

Child's Name: _____

Preference: ___ AM ___ PM ___ No Preference

Wrap Around/Extended Care Needed: ___ Yes ___ No ___ Unsure

Future 4 Waukesha (4K) Checklist

Child's Name: _____

Child's Birth Date: _____

First Day of Attendance at Current Site: _____

NOTE: Please use this checklist to make sure all the below items are returned to the School District. In order to be registered all lines MUST be checked. Registration will not be taken until a Future 4 Waukesha Community Partner or a school official checks all items.

- Proof of Residence (Current Utility Bill or Signed Lease)
 - A copy must be attached
- Parent/Guardian Picture ID (Verified)
- Birth Certificate (Verified)
- Self Address Stamped Envelope
- Enrollment Form
- Day Care Immunization Record
- Health History and Emergency Care Plan
- School District Census
- Home Language Survey
- Technology Acceptable Use Form

I certify that I have reviewed the above documents:

Community Partner or School Official Name

Date

Center or School Name

Contact Phone Number