SCHOOL DISTRICT OF SPRING VALLEY
Spring Valley, WI 54767

Today's Date:_____

ENROLLMENT/EMERGENCY FORM

STUDENT NAME: _____ **DOB:** _____ **GENDER:** ____

RACE: _____ **BIRTH CITY:**_____ **BIRTH STATE:**_____

1st PARENT(S) MR/MRS/MS _____ **PRIMARY PHONE:** _____

ADDRESS: _____
Street/P.O. Box City Zip

TOWNSHIP: _____ **COUNTY:** _____

MARITAL STATUS: ____ Married ____ Divorced ____ Separated ____ Single

CHILD RESIDES WITH: ____ Both ____ Father ____ Mother ____ Guardian

2nd PARENT(S) _____ **HOME PHONE:** _____

ADDRESS: _____
Street/P.O. Box City Zip

FATHER'S EMPLOYMENT: _____ **WORK PHONE:** _____

MOTHER'S EMPLOYMENT: _____ **WORK PHONE:** _____

PARENTS' CELL PHONE NUMBERS:_____/_____

E-MAIL ADDRESS: _____

FAMILY DOCTOR: _____ **ADDRESS:** _____ **PHONE:** _____

FAMILY DENTIST: _____ **ADDRESS:** _____ **PHONE:** _____

If we cannot reach YOU or the other parties you have designated, do we have your permission to contact your family doctor/dentist or the nearest doctor/dentist? ____ YES ____ NO

My child may be picked up by the following adults during the school year: (please list with phone numbers)

Name	Phone Number	Name	Phone Number
_____		_____	
_____		_____	
_____		_____	

****YOUR SIGNATURE:** _____ **DATE:** _____**

Comments/Concerns: _____

_____

IF ANY OF THE INFORMATION ON THIS SHEET SHOULD CHANGE, PLEASE CONTACT THE SCHOOL AT 778-5602 ASAP SO OUR INFORMATION IS KEPT UP TO DATE. THANK YOU!!

(OVER)

MEDICAL EMERGENCY SITUATIONS

If the Spring Valley School Employee(s), Teacher(s), or School Nurse(s) determine(s) that your child has become ill or injured at school (other than minor problems) you will be contacted as soon as possible, day or night. In an emergency situation where parents or guardians are unavailable, your child will be taken to an appropriate clinic or hospital for treatment.

We give consent for the treatment and for our insurance company to be billed.
Our primary medical clinic is _____

Parent's Signature _____ **Date** _____

EMERGENCY CONTACT NUMBERS IN CASE PARENTS/GUARDIANS CANNOT BE REACHED

NAME: _____ **1st PHONE:** _____
2nd PHONE: _____

NAME: _____ **1st PHONE:** _____
2nd PHONE: _____

MEDICAL INFORMATION

ALLERGIES: _____

_____

MEDICATION *ROUTINELY* TAKEN: _____

_____

MEDICAL CONDITIONS: _____

_____

AFTER SCHOOL INFORMATION

CIRCLE ONE: Bus Rider Or Walker
Bus Driver's Name: _____ **Bus Number:** _____

Does your child go to a babysitter on a regular basis? ___Yes ___ No
If yes, please answer the following:
Name: _____ **Phone:** _____
Schedule for babysitter: _____
Other siblings attending school: (Include name and classroom)

_____ _____

_____ _____

CENSUS INFORMAION

Please complete for young children who have not yet attended school.

NAME	GENDER	DATE OF BIRTH
_____	M F	_____
_____	M F	_____
_____	M F	_____
_____	M F	_____

SPRING VALLEY ELEMENTARY
Spring Valley, WI
Phone:1-715-778-5602

SPRING VALLEY STUDENT HEALTH INFORMATION

STUDENT'S FULL NAME_____ DOB_____

Has your child had a serious illness and/or injury? (Please describe and include the date)
Hospital: Date: Condition:

Does your child have:

Condition	Yes	No	Describe:
Attention Deficit Disorder			
Asthma			Treatment:
Seasonal Allergies			
Bee sting or insect allergy			
Food allergy			Food: Treatment:
Behavior concerns			
Mental health concerns			
Birth defects			
Blood disorder			
Dental problems			
Diabetes			
Frequent headaches			
Hearing problems			
Heart condition			
Orthopedic problem			
Seizures			What kind of seizure?: Treatment:
Toileting accidents and/or frequent urination			
Vision problem			
Other chronic condition			

**If your child currently has allergies, does he/she require an EPI-pen? ☐ YES ☐ NO
**If your child currently has asthma, does he/she require an inhaler or nebulizer? ☐ YES ☐ NO

Note: An Allergy Action plan, Asthma Action Plan, and Seizure Action Plan are **required** for all students with those health conditions. These forms will be sent to you by the School Nurse and **must** be filled out and signed by both your child's physician and a parent or guardian.

Primary Physician: _____ Clinic: _____
Clinic address: _____ Phone: _____

Family Dentist: _____ Clinic: _____
Clinic address: _____ Phone: _____

-over-

Medication:

A Nonprescription Medication Form must be completed and returned to the Health Office along with any nonprescription medication, in its original container. This form can be found on our District Website.

A Prescription Medication Form must be completed and returned to the Health Office along with any prescription medications. This form requires both a physician and parent signature. This form can be found on our District Website. Medication must be dropped off by a parent and be in its original container.

Emergency Contact:

Name: _____ Relationship: _____
Phone: _____

Secondary Emergency Contact:

Name: _____ Relationship: _____
Phone: _____

I hereby authorize the District Nurse, Health Assistant, Administrator, or other designated person to call any of the listed emergency contacts if needed for the care of my child. If my physician is not available (as listed) then an alternate physician may be contacted in an emergency. In case of a serious medical emergency or illness, 911 will be called. I authorize the release of any health information to the school district employees when necessary for the safety and educational benefit of my child.

Signature (Parent/Guardian): _____ Date: _____

Please contact the District School Nurse (715-778-5554 ext 2102) for any special health concern or change in health condition.

Spring Valley School District

Home of The Cardinals

1. Within the last 3 years, have you or anyone in your household moved for any reason?

YES ___ NO _____

2. Are you working or have you ever worked in agriculture in the last three years?

Yes___ No___

If you answered **NO** to either of these questions, please stop.

If you answered **YES**, please continue.

3. When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States?

Month_____ Year_____

4. Please check any of the agricultural activities listed below that you have looked for or worked in:

_____ Plant or harvest vegetables or fruits

_____ Canning vegetables or fruits

_____ Detassel corn

_____ Sod farm

_____ Tobacco farm

_____ Planting, pruning or cutting trees

_____ Poultry and/or egg farm

_____ Dairy farm

_____ Duck, turkey, chicken, pork or beef processing plant

_____ Flora culture/gladiola farm

_____ Aquaculture/fish hatcheries

_____ Green house or plant nursery

Spanish translation copy

1. ¿Durante los **últimos 3 años**, se ha mudado usted o alguien de su familia por alguna razón?

SÍ____ NO_____

2. ¿Trabaja o ha trabajado en la agricultura en los últimos tres años?

SÍ_____ NO_____

Si contestó **NO** a cualquiera de las dos preguntas, favor de parar aquí.

Si contestó **SÍ,** favor de continuar.

3. ¿Cuándo fue la última vez que usted o alguien de su familia se mudó para buscar o trabajar en una actividad agrícola dentro de los Estados Unidos?

Mes _____ Año _____

4. Por favor marque en la parte abajo la actividad agrícola en que usted buscó trabajo o trabajó.

____ Matadero de patos, pavos, pollos, cerdos o vacas

____ Enlatar o congelar verduras o frutas en la bodega

____ La espiga (maíz)

____ Trabajar en la siembra o cosecha de césped

____ Cultivar tabaco

____ Plantar, emparejar o cortar árboles

____ Pollería o granja de huevos

____ Granja de vacas lecheras

____Plantar o cosechar verduras o frutas

____ Cultivar y cosechar flores

____ Trabajar en un criadero de peces

____ Trabajar en la cría de plantas