School year _____ SS # _____

FRIEND PUBLIC SCHOOL STUDENT ENROLLMENT CARD

STUDENT'S NAME AS ON BIRTH CERTIFICATE OR LEGAL NAME			BIRTH DATE			STUDENT'S BIRTH PLACE		GRADE	SEX	PHONE NUMBERS
LAST	FIRST	MIDDLE NAME	MO.	DAY	YR.	CITY	STATE			HOME:
										CELL:
ADDRESS OF STUDENT										WORK:
STREET ADDRESS		CITY	STATE	ZIP		COUNTY	DIST. #			Email:

INFORMATION REGARDING LAST SCHOOL ATTENDED OTHER THAN FRIEND PUBLIC SCHOOL

NAME OF SCHOOL	ADDRESS	CITY	STATE	ZIP	DATE OF ENTRY	GRADE	DATE OF WITHDRAWAL	GRADE

INFORMATION REGARDING PERSON(S) WITH WHOM STUDENT IS LIVING

LAST NAME	FIRST	INITIAL	PLACE OF EMPLOYMENT	WORK PHONE NO.
LAST NAME	FIRST	INITIAL	PLACE OF EMPLOYMENT	WORK PHONE NO.

RELATIONSHIP OF ABOVE TO STUDENT

FATHER MOTHER STEPFATHER STEPMOTHER OTHER(PLEASE SPECIFY)

RACIAL/ETHNIC CLASSIFICATION OF STUDENT

ASIAN AMERICAN | BLACK AMERICAN | AMERICAN INDIAN | HISPANIC AMERICAN | WHITE AMERICAN | OTHER

DATE MOVED IN DISTRICT

MARITAL STATUS OF PARENTS

MARRIED DIVORCED OTHER (PLEASE SPECIFY)

FATHER: REMARRIED DECEASED

MOTHER: REMARRIED DECEASED

_____
STUDENT NO.

The information provided herein is true and complete to the best of the undersigned's knowledge.

Signature of Parent/Guardian _____

PLEASE FILL OUT FRONT AND BACK OF THIS FORM

ALL INFORMATION PROVIDED ON THESE FORMS IS USED BY OFFICIAL SCHOOL PERSONNEL IN COMPLIANCE WITH THE FAMILY RIGHTS AND PRIVACY ACT, PL - 93-380, SECTION 438.

Spl. Pioneer Publishing, Friend, NE 68359

IN CASE OF ILLNESS OR ACCIDENT, OR INCLEMENT WEATHER, IF NOT POSSIBLE TO REACH ME, PLEASE CALL:

Name of Person	Relationship	Home Phone #	Work Phone #
Name of Person	Relationship	Home Phone #	Work Phone #

IN CASE A PHYSICIAN IS URGENTLY NEEDED, PLEASE CALL THE PHYSICIAN NAMED BELOW:

Name of Physician	Address	Phone Number

BROTHERS AND SISTERS

Name	Place of Birth/Date of Birth	Name	Place of Birth/Date of Birth
Name	Place of Birth/Date of Birth	Name	Place of Birth/Date of Birth
Name	Place of Birth/Date of Birth	Name	Place of Birth/Date of Birth

Others in home: (List name and relationship)

_____

ELEMENTARY ONLY

Name of Babysitter/Day Care: _____ Address _____ Phone Number_____

In case of emergency closing of the school, my child has been instructed to (check and complete one)

Go straight home

Go home with/or to _____

Name Address Phone No.

DHHS

Nebraska Department Of Health & Human Services

IMMUNIZATION RECORD

Dear Parents:

School and child care immunization requirements reflect current medical recommendations and may require vaccines against any or all of the following diseases:

Measles	Diphtheria
Mumps	Tetanus
Rubella	Pertussis
Polio	Haemophilus influenzae (type b)
Hepatitis B	Chickenpox
Pneumococcal disease	

Consult your school nurse, child care provider, or health care provider for additional information. Please record in detail on this card all immunizations your child has received.

score

☐ In compliance ☐ Standard series complete ☐ Other

Do not write above this line. For school use only.

Child's Name: Last First Middle Initial Parent First Name

Street and Number Town County

Telephone Child's Birthdate Age in Years ☐ Male ☐ Female

Comments

FH-2 Rev. 12/10 (24302)
(Previous version 9/07 should be used.)

Child's Name (Last, First, M.I.): Child's Birthdate:

OPV/IPV (Polio)
Mo. & Yr. Given By

DTP/DT/DTaP/Td (Diphtheria-Tetanus-Pertussis)
Mo. & Yr. Given By

DT
Mo. & Yr.

Tdap
Mo. & Yr. Given By

Td
Mo. & Yr. Given By

M-M-R (Measles-Mumps-Rubella)
Day, Mo., Yr. Given By
#1
#2

Hib (Haemophilus influenzae type b)
Mo. & Yr. Given By

Hep B (Hepatitis B)
Mo. & Yr. Given By

Varicella (Chickenpox)
Day, Mo., Yr. Given By

or Date of Disease

PCV (Pneumococcal Conjugate)
Mo. & Yr. Given By

Other
Mo. & Yr. Given By

Medical Alert

I certify that the above information is correct to the best of my knowledge.

Signature of Parent or Doctor/Date

score

Friend Public School

501 S. Main Street/ P.O. Box 67, Friend, NE 68359
Phone: 402-947-2781 Fax: 402-947-2026
www.friendbulldogs.org

Administration

Superintendent: David Kraus
Principal: Elizabeth Stutzman
Counselor: Amy Hottovy
Activities Director: Jim Pfeiffer

ATTENTION: Principal/ Guidance Counselor/ Registrar

Please forward the records of _____
(Student's Name)

Permission is granted to release to the Friend Public Schools all information pertaining to my child's official school records. These records may include but are not limited to standardized tests, transcript of grades, health and immunization records, birth certificate, psychological data, attendance information, and special education records which should include documentation of student's placement and indication of parental permission.

_____
(Parent Signature)

_____
(Printed Name)

_____
(Date)

FORMER SCHOOL: _____
(Name of School)

_____
(Mailing Address)

_____
(Town State Zip)

According to the Final Regulations – Family Educational Rights and Privacy Act (Beckley Amendment dated June 17, 1976, it is not necessary to obtain written consent to release school records to other schools. It states in Section 99.31 that prior consent is not required if the disclosure is to officials of another school or school system in which the students seeks or intends to enroll.

_____ _____
(Administration Signature) (Title)

FRIEND PUBLIC SCHOOLS

Language and Educational History Questionnaire

Name _____ Date _____

Grade _____ Age _____ DOB _____

Language and Educational Background

1. What language did the student speak when they **began to talk**? _____
2. What language does the student speak most often **at home**? _____
3. What language do the adults speak most often **at home**? _____
4. The student speaks English only. ☐ yes ☐ no **(If you checked "yes," skip to question 8)**
5. The student speaks some/no English. Primary language spoken:

   _____
6. Please list the **additional languages** the student speaks or understands regardless the degree of proficiency.

   _____
7. Was the student influenced by an adult, other than the parents, such as a babysitter or a grandparent who spoke another language that may have affected the student's language skills? ☐ yes ☐ no

   If you checked "yes," please explain: _____
8. Has the student ever received instruction for English as a Learned Language? ☐ yes ☐ no
9. Has the student ever received instruction in a language other than English? ☐ yes ☐ no
10. Has the student ever received special education services? ☐ yes ☐ no If yes, give details: _____
11. Has the student ever received Title 1 services? ☐ yes ☐ no If yes, was it in math, reading, or both? (Please circle to indicate)
12. Has the student ever been retained at a grade level? ☐ yes ☐ no

- Return to Mrs. Clouse: File this form in student's cumulative folder.

Friend Public School – Student Health History

Student Name_____ Date of Birth _____ Sex M/F

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel, as needed, in order to promote your student's safety and educational success.

A. Current Health Status
   1. Does your student take medication or supplements regularly? Y N
      Please List:

   2. Does your child have a health condition now under treatment? Y N
      Please List:

   3. Does your child have allergies? Y N
      Please List:

   4. Date of last medical Exam: _____ Dr. _____

   5. Date of last Dental Exam: _____ Dr._____

   6. Does your child currently have health care insurance: Y N

   7. Would you like information about the state health Insurance program? Y N

B. Please circle any condition(s) your child has experienced:
   Sleeping Problem/Eating Problem/Coordination Problem/Tires easily/Recurrent Headaches/Weight Problem/Eczema/Behavioral Concerns/Asthma/Frequent Nosebleeds/Concussion/Broken Bone(s)/Heart Problems/ Pneumonia/Convulsions
      Dates affected: _____

C. Illness and Accidents
   1. More than one ear infection each year? Y N
   2. History of ear/hearing problems? Y N
   3. History of vision problems? Y N
   4. History of hospitalization or surgery? Y N
      Comments: _____

D. Prior History
   1. Significant complications during pregnancy? Y N
   2. Was pregnancy less than full-term? Y N
   3. Medical problems at birth? Y N
   4. Birth Weight: _____
   5. At what age did your child walk alone? _____
   6. At what age did your child say words with meaning? _____
   7. Was child enrolled in Early Childhood Special Education or Head Start? Y N Year_____

E. Family History
   1. Who lives in student's home? _____
   2. Any Family health Problems? _____

Parental Consent for Acetaminophen and/or Ibuprofen

I give permission for my child Receive the following medication please circle:

Acetaminophen (Tylenol) Ibuprofen

Student has taken Acetaminophen in the past: Y N Student has taken Ibuprofen in the past: Y N

Please notify me BEFORE administrating medication: Y N Please notify AFTER administration: Y N

Contact Name and Phone #_____

My child is taking other medications at this time: Y N

Please list: _____

Child is under the care of physician for the following:_____

Any special considerations/instructions:

_____

_____

_____ _____ _____

Completed by Relationship to Student Date