

School year _____

FRIEND PUBLIC SCHOOL STUDENT ENROLLMENT CARD

SS # _____

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:
ADDRESS OF STUDENT									CELL:	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					RACIAL/ETHNIC CLASSIFICATION OF STUDENT					
FATHER	MOTHER	STEPFATHER	STEPMOTHER	OTHER(PLEASE SPECIFY)	ASIAN AMERICAN	BLACK AMERICAN	AMERICAN INDIAN	HISPANIC AMERICAN	WHITE AMERICAN	OTHER
DATE MOVED IN DISTRICT		MARITAL STATUS OF PARENTS			FATHER		MOTHER		STUDENT NO. _____	
		MARRIED	DIVORCED	OTHER(PLEASE SPECIFY)	REMARRIED DECEASED	REMARRIED DECEASED				
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)

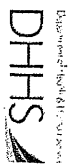
Go straight home

Go home with/or to _____

Name

Address

Phone No.



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

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

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

OPV/IPV (Polio)

Mo. & Yr.

Given By

DTP/DTPaP/Td (Diphtheria-Tetanus-Pertussis)

Mo. & Yr.

Given By

Hep B (Hepatitis B)

Mo. & Yr.

Given By

Variella (Chickenpox)

Day, Mo., Yr.

Given By

or Date of Disease

PCV (Pneumococcal Conjugate)

Mo. & Yr.

Given By

Tdap

Mo. & Yr.

Given By

Td

Mo. & Yr.

Given By

M-M-R (Measles-Mumps-Rubella)

Day, Mo., Yr.

Given By

#1

#2

Child's Birthdate:

Hib (Haemophilus influenzae type b)

Mo. & Yr.

Given By

Hep B (Hepatitis B)

Mo. & Yr.

Given By

Variella (Chickenpox)

Day, Mo., Yr.

Given By

or Date of Disease

PCV (Pneumococcal Conjugate)

Mo. & Yr.

Given By

Tdap

Mo. & Yr.

Given By

Td

Mo. & Yr.

Given By

M-M-R (Measles-Mumps-Rubella)

Day, Mo., Yr.

Given By

#1

#2

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

Medical Alert

Other

Mo. & Yr.

Given By

PCV (Pneumococcal Conjugate)

Mo. & Yr.

Given By

or Date of Disease

PCV (Pneumococcal Conjugate)

Mo. & Yr.

Given By

Variella (Chickenpox)

Day, Mo., Yr.

Given By

or Date of Disease

PCV (Pneumococcal Conjugate)

Mo. & Yr.

Given By

Hep B (Hepatitis B)

Mo. & Yr.

Given By

Variella (Chickenpox)

Day, Mo., Yr.

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Mo. & Yr.

Given By

Tdap

Mo. & Yr.

Given By

Td

Mo. & Yr.

Given By

M-M-R (Measles-Mumps-Rubella)

Day, Mo., Yr.

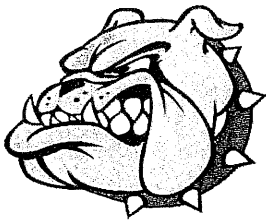
Given By

#1

#2

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