FRIEND PUBLIC SCHOOL STUDENT ENROLLMENT CARD

<table>
<thead>
<tr>
<th>STUDENT'S NAME AS ON BIRTH CERTIFICATE OR LEGAL NAME</th>
<th>BIRTH DATE</th>
<th>STUDENT'S BIRTH PLACE</th>
<th>GRADE</th>
<th>SEX</th>
<th>PHONE NUMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAST</td>
<td>FIRST</td>
<td>MIDDLE NAME</td>
<td>MO</td>
<td>DAY</td>
<td>YR</td>
</tr>
<tr>
<td>HOME:</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>STREET ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>COUNTY</th>
<th>DIST. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS OF STUDENT</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

INFORMATION REGARDING LAST SCHOOL ATTENDED OTHER THAN FRIEND PUBLIC SCHOOL

<table>
<thead>
<tr>
<th>NAME OF SCHOOL</th>
<th>ADDRESS</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>DATE OF ENTRY</th>
<th>GRADE</th>
<th>DATE OF WITHDRAWAL</th>
<th>GRADE</th>
</tr>
</thead>
</table>

INFORMATION REGARDING PERSON(S) WITH WHOM STUDENT IS LIVING

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST</th>
<th>INITIAL</th>
<th>PLACE OF EMPLOYMENT</th>
<th>WORK PHONE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

RELATIONSHIP OF ABOVE TO STUDENT

<table>
<thead>
<tr>
<th>FATHER</th>
<th>MOTHER</th>
<th>STEPFATHER</th>
<th>STEPMOTHER</th>
<th>OTHER (PLEASE SPECIFY)</th>
</tr>
</thead>
</table>

RACIAL/ETHNIC CLASSIFICATION OF STUDENT

<table>
<thead>
<tr>
<th>ASIAN</th>
<th>AMERICAN</th>
<th>AMERICAN</th>
<th>INDIAN</th>
<th>HISPANIC</th>
<th>AMERICAN</th>
<th>AMERICAN</th>
<th>OTHER</th>
</tr>
</thead>
</table>

DATE MOVED IN DISTRICT

<table>
<thead>
<tr>
<th>MARRIED</th>
<th>DIVORCED</th>
<th>OTHER (PLEASE SPECIFY)</th>
<th>REMARRIED DECEASED</th>
<th>REMARRIED DECEASED</th>
</tr>
</thead>
</table>

STUDENT NO.

Signature of Parent/Guardian ________________________________

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

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:

<table>
<thead>
<tr>
<th>Name of Person</th>
<th>Relationship</th>
<th>Home Phone #</th>
<th>Work Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Name of Person

Relationship

Home Phone #

Work Phone #

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

<table>
<thead>
<tr>
<th>Name of Physician</th>
<th>Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

BROTHERS AND SISTERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Place of Birth/Date of Birth</th>
<th>Name</th>
<th>Place of Birth/Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Others in home: (List name and relationship)

<table>
<thead>
<tr>
<th>Name</th>
<th>Place of Birth/Date of Birth</th>
<th>Name</th>
<th>Place of Birth/Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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.
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
- Haemophilus influenzae type b
- Pneumococcal disease
- Diphtheria
- Tetanus
- Pertussis
- 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.

In compliance

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

<table>
<thead>
<tr>
<th>Child's Name: Last, First, M.I.</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPV/IPV (Polio) Mo. &amp; Yr.</td>
<td>Given By</td>
</tr>
<tr>
<td>DTP/DT/DTaP/Td (Diphtheria-Tetanus-Pertussis) Mo. &amp; Yr.</td>
<td>Given By</td>
</tr>
<tr>
<td>DT Mo. &amp; Yr.</td>
<td>Given By</td>
</tr>
<tr>
<td>Tdap Mo. &amp; Yr.</td>
<td>Given By</td>
</tr>
<tr>
<td>M-M-R (Measles-Mumps-Rubella) Day, Mo, Yr.</td>
<td>Given By</td>
</tr>
</tbody>
</table>

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
POV (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
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)
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.
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/Tries 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 ________________________________