

SCHOOL DISTRICT OF ST. CROIX FALLS

Student Registration Information

Registration Date: _____ Starting Date: _____ Grade: _____

Student's Name: _____
(first) (middle) (last)

Home Phone: _____ Student Cell Phone: _____

Birth City: _____ Birth County: _____ Birth State: _____

Birth Date: ____/____/____ Gender: M F Hispanic/Latino: Yes No

Please choose one or more of the following: American Indian/Alaska Native

Native Hawaiian or Other Pacific Islander Asian Black/African American White

Mailing Address _____ City _____ Zip: _____

Physical Address: _____ City: _____ Zip: _____

Student lives with:

Name: _____ Relationship: _____

Employer: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Name: _____ Relationship: _____

Employer: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Parents are: married _____ divorced _____ separated: _____ single: _____

Second mailing (if applicable, i.e. joint custody, non-custodial parent):

Name: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____

List other children in the family: (name, birth date, and gender.)

Name: _____ / / _____ Male Female

Name: _____ / / _____ Male Female

Name: _____ / / _____ Male Female

For office use only:

Teacher _____ Student # _____ Lunch # _____ Locker # _____ PS Log In _____ SEG _____

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Emergency Contact (when parent cannot be reached)

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Screening checklist for new students enrolling in the School District of St. Croix Falls

- | Yes | No | |
|------------|-----------|---|
| _____ | _____ | Has your child required previous special education (IEP)? |
| _____ | _____ | Has your child required previous counseling services? |
| _____ | _____ | Has your child ever been expelled from school? |
| _____ | _____ | Has your child had any behavior or social adjustment problems? |
| _____ | _____ | Has your child had any previous math or reading problems? |
| _____ | _____ | Has your child had any previous health or physical problems of concern to the school? |

Previous School Attended _____

Will your child be riding the bus to school? _____ yes _____no

St. Croix Falls School District Parent/Guardian Home Language Survey

NAME/GRADE OF STUDENT	
Name	Grade

Relationship of Person Completing Survey

Mother Father Guardian Other *Specify*

Directions: Check the correct response for each of the following questions and indicate other languages if appropriate.

- | | English | Other Language(s) |
|---|--------------------------|--------------------------|
| 1. What language did the child learn when she/he first began to talk? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. What language does the family speak at home most of the time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. What language does the parent(s) speak to her/his child most of the time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. What language does the child speak to her/his parent(s) most of the time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. What language does the child hear and understand in the home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. What language does the child speak to her/his brothers/sisters? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. What language does the child speak to her/his friends most of the time? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | |
| | Yes | No |
| 8. Can an adult family member or extended family member speak English? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Can they read English? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do the parents/guardians request oral and/or written communication from the school to be in English?
If no, in what language | <input type="checkbox"/> | <input type="checkbox"/> |

SIGNATURE

Signature of Person Completing Survey	Date Signed
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FOR STAFF COMPLETION – TO BE COMPLETED FOR ALL NEW ELL STUDENTS			
ELL File Opened Yes No <input type="checkbox"/> <input type="checkbox"/>	Today's Date	ELL Test Date	Test
ELL Evaluator	ELL Level	Placement	

School District of St. Croix Falls

P.O. Box 130 ~ St. Croix Falls ~ Wisconsin 54024 ~ (715) 483-2507 ~ Fax (715) 483-3695

MARK BURANDT
DISTRICT
ADMINISTRATOR

JEFFREY BENOY
ELEMENTARY
PRINCIPAL

JOE CONNORS
MIDDLE SCHOOL
PRINCIPAL

PEGGY RYAN
HIGH SCHOOL
PRINCIPAL

Request for Transcripts

Date _____

Previous School: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Dear Registrar,

Please send us the complete records for the following student who has enrolled in our school district.

Name: _____ Grade: _____ DOB: _____

Please forward the cumulative records including:

- * Date of entrance and withdrawal
- * Transcript
- * Test scores
- * WIAA Physical
- * Immunization records
- * IEP, special education, etc
- * Other pertinent information

In compliance with the State Law (Sec. 118.125, Wisconsin Statutes) we have received permission from the parents of the above listed child for the release of records to the St. Croix Falls Schools.

Please send records to the appropriate school.

St. Croix Falls Elementary
Randi Shaw
Grades 4K-4
715-483-9826 ext 1100
Fax: 715-483-7093
email: shawra@scfschools.com

St. Croix Falls Middle School
Kelly Anderson
Grades 5-8
715-483-9825 ext 1406
Fax: 715-483-2591
email: andcke@scfschools.com

St. Croix Falls High School
Shelley Skemp
Grades 9-12
715-483-9824 ext 1300
Fax: 715-483-5055
email: skempsh@scfschools.com

ST. CROIX FALLS
SCHOOL DISTRICT
IS AN EQUAL
OPPORTUNITY
EMPLOYER
AND DOES NOT
DISCRIMINATE
ON THE BASIS OF
SEX, RACE,
NATIONAL ORIGIN, AGE,
RELIGION,
ANCESTRY,
CREED, PREGNANCY,
MARITAL/PARENTAL
STATUS, SEXUAL
ORIENTATION, DISABILITY
OR HANDICAP