



West Allis - West Milwaukee  
**ANNUAL STUDENT EMERGENCY CONTACT FORM**  
 2013-2014 School Year

Student Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Male \_\_\_ Female \_\_\_  
 Student Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Current Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

**Parent/Guardian Additional Emergency Contact Information**

Please complete the following information and relationship to the student (such as Birth Parent /Step-Parent/Legal Guardian, etc.).

**#1. My child lives with the following Adults at the Student Address above:**

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

**LIST NAMES OF OTHER SIBLINGS LIVING AT THE ABOVE ADDRESS**

SIBLING NAME	DATE OF BIRTH	GRADE	SCHOOL ATTENDING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**#2. Additional Parent or Legal Guardian information of Adults NOT living with my child include the following:**

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail Address \_\_\_\_\_

CHECK HERE IF **LEGAL RESTRICTIONS** ARE IN EFFECT. LIST PERSONS NOT ALLOWED TO SEE STUDENT IN SCHOOL OR PERSONS NOT ALLOWED TO PICK UP STUDENT. **\*\* PROVIDE ANY PERTINENT LEGAL DOCUMENT STATING THESE RESTRICTIONS. \*\***

\_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_

**#3. The following emergency contacts may be contacted in the event that the parent/guardians above cannot be reached:**

1. Name \_\_\_\_\_ Relationship To Student \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 2. Name \_\_\_\_\_ Relationship To Student \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**#4. In the event of an emergency school closing where phones lines are not available my child is aware to do the following:**

**Walk Directly Home**       **Take The Bus Directly Home As Usual**       **Walk to the following home:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

(over)

WEST ALLIS-WEST MILWAUKEE  
ANNUAL STUDENT HEALTH CONDITION FORM

Name \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_ School \_\_\_\_\_

Please check here if your child has no existing health conditions

Do you carry Health Insurance for your child?  Yes  No (if no please check the following statement)  
Badger Care Plus is the State of Wisconsin Health Insurance Program. It can provide affordable high quality health care coverage to all children. Would you like information on how to get Badger Care Plus for your child?  Yes  No  
(By checking yes, your name will be forwarded to the West Allis Health Department to provide further assistance with the simple application process.)

My child wears glasses/contact lenses  Yes  No      My child wears a hearing aid  Yes  No

**IMPORTANT:** The following information will help us provide appropriate care for your child. Please check and comment on any serious health condition(s) your child may have:

<input type="checkbox"/> Asthma/breathing problem --Please complete an asthma care plan	<input type="checkbox"/> Surgery in the last 12 months _____
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Takes prescription medication Please list below: _____
<input type="checkbox"/> Seizures Last seizure was: _____	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> ADHD Hyperactive: _____ Inattentive: _____	
<input type="checkbox"/> Bowel/Bladder Concerns _____	
<input type="checkbox"/> Mental Health Concerns _____	
<input type="checkbox"/> Other Health Concerns _____	

If you would like further assistance regarding your child's health care needs,  
please contact the District Nursing Office at 414-604-4000 x1107

Allergies (Circle: food, plant, medication, animal, latex, bees, other)  
List: \_\_\_\_\_

Does your child have an EPI Pen?  Yes\*  No

If you checked YES, a medication authorization form must be completed by your child's doctor and an EpiPen must be sent to school. Contact the school office for the appropriate forms.

In case of illness at school, the school principal or designee will contact the West Allis Fire Department Emergency Medical Services at 911 if emergency medical care is needed. The West Allis Fire Department or assigned ambulance service will convey your child to a hospital providing emergency care. It is a parental responsibility to assume all conveyance and medical expenses incurred on behalf of your child.

Preferred Hospital \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

I hereby give my consent for my child's name and health condition to be shared confidentially with professional and lay staff as determined by the principal. This consent shall remain in force until revoked by me by written notice to the principal.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian)

## INSTRUCTIONS FOR APPLYING

**Part 1:** All Household Members (**a household member is any child or adult living with you**): All applicants should complete this part. List the name of each household member, the name of the school each child attends, and the child's grade. If the child is a foster child, check the box for foster child. If a household member has no income, check the box for no income. All household members, including foster children, should be included here. If you need additional space, attach a separate piece of paper.

If anyone in your household receives benefits from **FoodShare, W-2 Cash Benefits, or the Food Distribution Program on Indian Reservations (FDPIR)**, follow these instructions.

**Part 2:** List the case number for one household member (adult or child) who receives FoodShare or W-2 Cash Benefits or FDPIR benefits.

**Part 3:** Skip this part.

**Part 4:** Skip this part.

**Part 5:** Sign the form. You do **not** need to provide the last four digits of your Social Security Number.

**Part 6:** This question is optional. You can choose whether or not to provide ethnic and racial data.

If you are applying for a child who is **homeless, a migrant or runaway**, follow these instructions.

**Part 2:** Skip this part.

**Part 3:** Check the appropriate category and call the School District Homeless Liaison at (414) 604-3123.

**Part 4:** Skip this part.

**Part 5:** Sign the form. You do **not** need to provide the last four digits of your Social Security Number.

**Part 6:** This question is optional. You can choose whether or not to provide ethnic and racial data.

If you are applying for *only* foster child(ren), follow these instructions. You do **not** need to fill out a separate application for each foster child in your household. (If there are both foster children and non-foster children in your household, follow the instructions below for All Other Households).

If **all** children in the household are marked as foster children in Part 1:

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Skip this part.

**Part 5:** Sign the form. You do **not** need to provide the last four digits of your Social Security Number.

**Part 6:** This question is optional. You can choose whether or not to provide ethnic and racial data.

**ALL OTHER HOUSEHOLDS**, including WIC households and households with both foster children and non-foster children, follow these instructions:

**Part 2:** Skip this part.

**Part 3:** If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call the School District Homeless Liaison at (414) 604-3123. If not, skip this part.

**Part 4:** Follow these instructions to report total household income from **this month or last month**.

- **Section 1—Name:** List all household members who have income.
- **Section 2—Gross Income and How Often It Was Received:** List the income for each household member. Check the box to tell us how often the person receives the income—weekly, every other week, twice a month, or monthly.
  - **Earnings from work:** List the **gross income**, not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you. Net income should *only* be reported for self-owned business, farm, or rental income.
  - **Welfare, Child Support, Alimony:** List the amount each person receives, and check the box to tell us how often.
  - **Pensions, Retirement, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits.** List the amount each person receives, and check the box to tell us how often they receive it.
  - **All Other Income:** List Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household and any other income received weekly, every other week, twice a month, monthly, quarterly, or annually. Do not include income from FoodShare, FDPIR, WIC, Federal education benefits and foster payments received by your family from the placing agency.
  - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

**Part 5:** An adult household member must sign the form and list the last four digits of their Social Security Number (or write "none" if s/he doesn't have one). Writing "none" does **not** prevent your child(ren) from qualifying to receive free or reduced priced meals.

**Part 6:** This question is optional. You can choose whether or not to provide ethnic and racial data.

**Free and Reduced Price School Meal Application**

School Year 2013-2014

Instructions for Applying

Page 1 of 1

## FREE AND REDUCED PRICE SCHOOL MEALS FAMILY APPLICATION

PART 1. ALL HOUSEHOLD MEMBERS				
Names of <u>all</u> people living in your household (First, Middle Initial, Last)	School the child attends, or indicate "NA" if household member is not in school	Grade	Check if a foster child (legal responsibility of welfare agency or court) If all children listed below are foster children, skip to Part 5 to sign this form.	Check if NO income
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

PART 2. BENEFITS
If <b>any</b> member of your household receives <b>FoodShare, FDPIR or W-2 Cash Benefits</b> , provide the name and case number for the person who receives benefits and <b>skip to part 5</b> . If no one receives these benefits, go to Part 3. NAME: _____ CASE NUMBER: _____

PART 3. HOMELESS, MIGRANT, RUNAWAY STATUS
If any child you are applying for is homeless, migrant, or a runaway check the appropriate box and call the School District Homeless Liaison at (414) 604-3123. HOMELESS <input type="checkbox"/> MIGRANT <input type="checkbox"/> RUNAWAY <input type="checkbox"/>

PART 4. TOTAL HOUSEHOLD GROSS INCOME (before deductions). List all income on the same line as the person who receives it. Check the box for how often it is received. Record each income only once. If you provided a case number in Part 2, you do <b>not</b> need to provide income information.															
1. NAME (List only household members with income)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED														
Earnings from work before deductions.	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Pensions, retirement, Social Security, SSI, VA benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All Other Income (indicate frequency, such as "weekly" "monthly" "quarterly" "annually")
<i>(Example) Jane Smith</i>	\$200	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$150	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50 / quarterly
\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ / _____
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\$		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$ / _____

PART 5. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)
An adult household member must sign the application. If Part 4 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or write "none" if you do not have a Social Security Number. (See Privacy Act Statement on the back of this page.) I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted.
Sign here: _____ Print name: _____ Date: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: _____ Cell Phone Number: _____ Last four digits of Social Security Number (Write "None" if you do not have a Social Security Number): *** - * * - _____

PART 6. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)	
Choose one ethnicity:	Choose one or more (regardless of ethnicity):
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American
<input type="checkbox"/> Not Hispanic/Latino	<input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or other Pacific Islander



School District of West Allis-West Milwaukee, et al. EDUCATIONAL ADMINISTRATION CENTER

July, 2013

Dear Parents/Guardians:

The School District realizes that despite our efforts to protect students from injury while at school, accidents can and will occur.

Since the School District does not carry medical insurance to cover students injured in our facilities, all hospital and doctor bills incurred due to an accident are the responsibility of the student and his/her parents or guardians. For this reason, it is recommended that your child have protection through some type of medical insurance.

The program is underwritten by Security Life Insurance Company of America located in Minnetonka, Minnesota and administered by Student Assurance Services, Inc. of Stillwater, Minnesota.

Attached is a copy of the enrollment brochure, which includes premium rates. Please save this brochure for future reference.

- 1. If you do not feel your insurance is adequate because of a deductible or co-insurance clause, or if you do not have insurance, we encourage you to review the student accident insurance program.
2. Parents desiring the school accident insurance coverage are to return the completed enrollment form and premium to the school within 10 days. Coverage does not become effective until the school receives the premium. PLEASE FILL IN THE APPLICATION COMPLETELY.
3. Please make checks or money orders payable to Student Assurance Services, Inc. Print the student's name on the face of the check.
4. All questions concerning student claims are to be directed to Sonny Heinrich, Agent, 1-800-328-2739.
5. In case of an accident, contact your school office for a claim form.
6. Under the School Year Plan, coverage has also been provided for insured students enrolled in organized and supervised activities of the Recreation Department during the school year and summer months. Activities covered would include the following: Boy's Clubs, Girls' Clubs, social centers, swimming, dancing, and baseball. The person in charge must have a list of the students enrolled in each activity.
7. Pupils on the playground for free play without supervision are not covered unless they have 24-hour coverage. Scouting is not considered a school function; and therefore, would not be covered unless it were under the 24-hour plan. All interscholastic athletic activities are covered under the special athletic premium.

IF YOU DO NOT WISH TO HAVE YOUR CHILD COVERED BY THIS INSURANCE, PLEASE SIGN THE ATTACHED WAIVER AND RETURN IT TO YOUR CHILD'S TEACHER.

Sincerely,

Handwritten signature of Deborah L. Rouse

Deborah L. Rouse
Director of Business Services

\*\*\*\*\*

PARENTAL ACCIDENT INSURANCE WAIVER 2012/2013

We have adequate insurance to protect the student listed below in case of an accident.

Student's Name \_\_\_\_\_ School \_\_\_\_\_

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



**School District of  
West Allis-West Milwaukee, et al.  
EDUCATIONAL ADMINISTRATION CENTER**

**NOTICE OF REFUSAL TO RELEASE DIRECTORY DATA**

On an annual basis, the School District of West Allis - West Milwaukee, et al. must notify parents, guardians, and eligible students (age 18 or older) of their right under state and federal law to withhold release of any or all "directory data" information. Directory data is defined as the following information:

- Name  Address  Phone Number  Date and Place of Birth  Major Field of Study  Dates of Attendance
- Participation in officially recognized activities and sports  Dates of Attendance
- Weight and height of members of athletic teams  Degrees and awards received

If the District does not receive this **Notice of Refusal to Release Directory Data Form** within 14 days, the District may disclose "directory data" to anyone who requests it without the parent's consent.

Under the No Child Left Behind Act, if the district does not receive parent notice to withhold directory data information, the District must disclose the following information upon request:

1. Names and addresses of students expected to graduate during the current school year to colleges/universities and technical schools.
2. Names, addresses and phone numbers to Branches of the Armed Services including Air Force, Navy, Army, Marine Corp, and National Guard.

**NOTICE OF REFUSAL TO RELEASE DIRECTORY DATA FORM**

**I DO NOT WISH FOR THE DISTRICT TO DISCLOSE ANY DIRECTORY DATA REGARDING MY CHILD/CHILDREN; THEREFORE, PLEASE WITHHOLD DIRECTORY DATA RELATED TO THE FOLLOWING STUDENTS:**

Student's Name:	School:	Grade:
Student's Name:	School:	Grade:
Student's Name:	School:	Grade:
Student's Name:	School:	Grade:

\_\_\_\_\_  
Signature Parent/Guardian/Eligible Student (18 or older)

\_\_\_\_\_  
Date

**Please return this form within 14 days to your child's school.**

**Office Use Only: A copy of this form must be forwarded to the Student Service Office, Administration Building, 1205 S. 70<sup>th</sup> Street, West Allis, WI 53214**