School District of Spring Valley

Home of the Cardinals

PERMISSION TO RELEASE RECORDS

AS A PARENT/GUARDIAN OF:

_____

STUDENT NAME GRADE DOB

_____

STUDENT NAME GRADE DOB

_____

STUDENT NAME GRADE DOB

I HEREBY GRANT PERMISSION TO THE SCHOOL OFFICE OF:

_____

SCHOOL DISTRICT

_____

ADDRESS

_____

CITY STATE ZIP CODE PHONE #

TO RELEASE/OBTAIN THE FOLLOWING RECORDS TO/FROM:

SPRING VALLEY SCHOOLS
S1450 COUNTY RD CC, SPRING VALLEY WI, 54767

PROGRESS RECORDS
RECORDS OF ACADEMIC PERFORMANCE
ATTENDANCE
STANDARDIZED TEST RESULTS
IMMUNIZATION RECORDS
OTHER _____

BEHAVIORAL RECORDS
PSYCHOLOGICAL EVALUATION REPORTS
HEALTH RECORDS
504 PLAN
REGULAR EDUCATION PLAN
SPECIAL EDUCATION PLAN
OTHER _____

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____Date: _____

SPRING VALLEY MIDDLE/HIGH SCHOOL NEW STUDENT ENROLLMENT FORM (PG 1)

STUDENT NAME _____ DOB:_____ GRADE_____

FAMILY INFORMATION :

PARENT/GUARDIANS (FAMILY 1) _____

ADDRESS: _____
STREET/PO BOX/CITY/STATE/ZIP CODE
MOTHER CELL _____ FATHER CELL _____

HOME PHONE _____

MOTHER EMAIL _____ FATHER EMAIL _____

MOTHER EMPLOYMENT _____
DAYTIME PHONE NUMBER _____

FATHER EMPLOYMENT _____
DAYTIME PHONE NUMBER _____

If Applicable:
PARENT/GUARDIANS (FAMILY 2) _____

ADDRESS: _____
STREET/PO BOX/CITY/STATE/ZIP CODE
MOTHER CELL _____ FATHER CELL _____

HOME _____

MOTHER EMAIL _____ FATHER EMAIL _____

MOTHER EMPLOYMENT _____
DAYTIME PHONE NUMBER _____

FATHER EMPLOYMENT _____
DAYTIME PHONE NUMBER _____

Student Resides With: Family 1 ⬜ Family 2 ⬜

School District of Spring Valley

Home of the Cardinals

SPRING VALLEY MIDDLE/HIGH SCHOOL NEW STUDENT ENROLLMENT FORM (PG 2)

OTHER SIBLINGS IN DISTRICT:

STUDENT NAME_____ DOB:_____ GRADE_____

STUDENT NAME_____ DOB:_____ GRADE_____

STUDENT NAME_____ DOB:_____ GRADE_____

WILL STUDENT(S) BE TRANSPORTED TO/FROM SCHOOL USING DISTRICT BUS?

⬜ YES ⬜ NO

If yes, please call the bus garage at 715-778-5609 to speak with our transportation director and arrange bussing. *(Please note, if open-enrolling from another district, transportation may not be available.)*

PHOTO PERMISSION:

Do we have permission to publish photos of your child including their name in district marketing materials? This is including but not limited to district newsletters, social media and our website.

⬜ YES ⬜ NO

MILITARY PARENT:

Is either parent or guardian active duty in the military? ⬜ YES ⬜ NO

Is either parent or guardian a traditional member of the Guard or Reserve?

⬜ YES ⬜ NO

Is either parent or guardian a member of the Active Guard/Reserve (AGR) under Title 10 or full time National Guard under Title 32? ⬜ YES ⬜ NO

US DEPARTMENT OF EDUCATION REQUIREMENTS:

This student is identified as:

⬜ HISPANIC/LATINO ⬜ **NOT** HISPANIC/LATINO

And by **ONE OR MORE** of the following groups:

⬜ American Indian/Alaska Native ⬜ Asian ⬜ White

⬜ Black/African American ⬜ Native Hawaiian/Other Pacific Islander

Parent/Guardian Signature: _____

Date: _____

School District of Spring Valley

Home of the Cardinals

SPRING VALLEY MIDDLE/HIGH SCHOOL HANDBOOKS

STUDENT NAME _____ DOB:_____ GRADE_____

Spring Valley Middle/High School Handbook

Please review the Spring Valley Middle/High School Handbook here:
https://docs.google.com/document/d/14KpCz4fw3ysw6G7aYvRi23hLwgI1UXyzHMigNRMxVvg/edit

I have read and discussed the 2024/2025 Spring Valley Middle-High School Handbook with my student and fully understand its contents.

☐ YES ☐ NO

Parent/Guardian Signature: _____

Student Signature_____

Date: _____

Internet Use

Our internet use policy can be viewed here:
https://www.springvalley.k12.wi.us/common/pages/DisplayFile.aspx?itemId=1019147

I have read and understand the School District of Spring Valley's Internet Use Policy.

☐ YES ☐ NO

Parent/Guardian Signature: _____

Student Signature_____

Date: _____

HIGH SCHOOL ONLY - 1:1 Device

Please review the 1:1 Device Policy here:
https://docs.google.com/document/d/1WnL0KpZ-51zM2kMR30jYm4-bavjr14sSrWaiihVZXZs/edit?usp=sharing

I have read and agree to the 1:1 device policy and want my student to participate in the program.

☐ YES ☐ NO

Parent/Guardian Signature: _____

High School Student Signature_____

Date: _____

SPRING VALLEY MIDDLE/HIGH SCHOOL
TECHNOLOGY AT HOME SURVEY

To be completed for all students: Closing the digital equity gap is a priority to ensure high-quality learning for all children in Wisconsin through access to robust broadband and digital learning resources, especially in rural areas and other groups lacking internet access.

STUDENT NAME _____ DOB:_____ GRADE_____

1. Can the student access the internet on their primary learning device at home?
   ☐ YES ☐ NO

2. If the student is unable to access the internet at their primary place of residence, why not?
   ☐ Not Desired ☐ Not Affordable ☐ Not Available ☐ Other

3. What is the primary type of internet service used at the residence?
   ☐ Broadband ☐ Cellular ☐ Hot Spot ☐ WiFi
   ☐ DialUp ☐ Other ☐ Unknown

4. Can the student stream video on their primary learning device without interruption?
   ☐ YES ☐ NO ☐ Sometimes (not consistently)

5. What device does the student use most often at home?
   ☐ Desktop ☐ Laptop ☐ Tablet ☐ Smartphone
   ☐ None ☐ Other

6. Who provided the primary learning device to the student?
   ☐ School ☐ Personal ☐ Other

7. Is the primary learning device shared with anyone else in the household?
   ☐ Shared ☐ Not Shared

School District of Spring Valley

Home of the Cardinals

SPRING VALLEY MIDDLE/HIGH SCHOOL HOME LANGUAGE SURVEY
(PG 1)

To be completed for all students: the completion of a home language survey is a requirement under WI Statutes PI 13 for all districts in the state of Wisconsin. Your cooperation in providing the following information is appreciated.

Student Information:

Date:		
First Name:	Middle Initial:	Last Name:
School Name:	Grade:	Date of Birth: (mm/dd/yyyy)
Language(s) **other than English** used by student:		

Parent/Guardian Information:

First Name	
Last Name	
Relationship to Student	
First Name	
Last Name	
Relationship to Student	

Parental/Guardian preference for languages used for school communications (may be multiple):

Parental/Guardian name: _____
Oral Language: _____
Written Language: _____

Parental/Guardian name: _____
Oral Language: _____
Written Language: _____

Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

Date: _____

SPRING VALLEY MIDDLE/HIGH SCHOOL HOME LANGUAGE SURVEY
(PG 2)

To be completed for all students: the completion of a home language survey is a requirement under WI Statutes PI 13 for all districts in the state of Wisconsin. Your cooperation in providing the following information is appreciated.

Was the first language used by this student English?

☐ YES ☐ NO

If no, what language? _____

When at home, does this student hear or use a language other than English more than half the time?

☐ YES ☐ NO

If yes, what language? _____

When interacting with their parents or guardians, does this student hear or use a language other than English more than half of the time?

☐ YES ☐ NO

If yes, what language? _____

When interacting with caregivers other than their parents or guardians, does this student hear or use a language other than English more than half of the time?

☐ YES ☐ NO

If yes, what language? _____

When interacting with their siblings or other children in their home, does this student hear or use a language other than English more than half of the time?

☐ YES ☐ NO

If yes, what language? _____

Is this student a Native American, Native Alaskan, or Native Hawaiian? Is this student's language influenced by a Tribal language through a parent, grandparent, relative, or guardian?

☐ YES ☐ NO

Has this student recently moved from another school district where they were identified as an English Learner?

☐ YES ☐ NO

School District of Spring Valley

Home of the Cardinals

SPRING VALLEY MIDDLE/HIGH SCHOOL STUDENT HEALTH INFORMATION (PG 1)

STUDENT NAME _____ DOB:_____ GRADE_____

Has your child had a serious illness or injury? (Please describe and include the date).
Hospital:
Date:
Condition(s):

Does your child have:

Condition	Yes	No	Describe:
Attention Deficit Disorder			
Seasonal Allergies			
Bee sting or insect allergy			
Food allergy			Food: Treatment:
Behavior concerns			
Mental health concerns			
Birth defects			
Blood disorder			
Dental problems			
Diabetes			
Frequent headaches			
Hearing problems			
Heart condition			
Orthopedic problem			
Seizures			What kind of seizure?: Treatment:
Toileting accidents and/or frequent urination			
Vision problem			
Other chronic condition			

**If your child currently has allergies, does he/she require an EPI-pen?
☐ YES ☐ NO
**If your child currently has asthma, does he/she require an inhaler or nebulizer?
☐ YES ☐ NO
Note: An Allergy Action plan, Asthma Action Plan, and Seizure Action Plan are **required** for all students with those health conditions. These forms will be sent to you by the School Nurse and **must** be filled out and signed by both your child's physician and a parent or guardian.

SPRING VALLEY MIDDLE/HIGH SCHOOL
STUDENT HEALTH INFORMATION (PG 2)

Primary Physician: _____
Clinic:_____
Clinic address:_____
Phone:_____

Family Dentist:_____
Clinic:_____
Clinic address:_____
Phone:_____

Medication:
A Nonprescription Medication Form must be completed and returned to the Health Office along with any nonprescription medication, in its original container. This form can be found on our District Website.
A Prescription Medication Form must be completed and returned to the Health Office along with any prescription medications. This form requires both a physician and parent signature. This form can be found on our District Website. Medication must be dropped off by a parent and be in its original container.

Emergency Contact:
Name:_____
Relationship:_____
Phone:_____

Secondary Emergency Contact:
Name:_____
Relationship:_____
Phone:_____

I hereby authorize the District Nurse, Health Assistant, Administrator, or other designated person to call any of the listed emergency contacts if needed for the care of my child. If my physician is not available (as listed) then an alternate physician may be contacted in an emergency. In case of a serious medical emergency or illness, 911 will be called. I authorize the release of any health information to the school district employees when necessary for the safety and educational benefit of my child.

Parent/Guardian Signature:_____

Date:_____

Please contact the District School Nurse (715-778-5602 ext 3104) for any special health concern or change in health condition.

School District of Spring Valley

Home of the Cardinals

SPRING VALLEY MIDDLE/HIGH SCHOOL NEW STUDENT SCREENING FOR EXCEPTIONAL EDUCATIONAL NEEDS & OTHER STUDENT SERVICES

STUDENT NAME _____ DOB:_____ GRADE_____

Physical Disability	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Cognitive Disability	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Hearing Impairment	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Vision Impairment	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Speech and/or Language Disability	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Emotional Disturbance	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Learning Disability	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Traumatic Brain Injury	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Autism	☐ Diagnosed	☐ Suspected	☐ Not Apparent
Gifted/Talented	☐ Diagnosed	☐ Suspected	☐ Not Apparent

Other (Check all that apply)

☐ Remedial Reading ☐ Remedial Math ☐ Alternative School
☐ School Social Work ☐ 504 Accommodation Plan ☐ School Counseling
☐ Other (Please specify):

Has your child ever been expelled from school (or otherwise forced to withdraw?)

☐ YES ☐ NO

If yes, please describe the reason and term of expulsion:

Parent/Guardian Signature: _____

Date: _____

School District of Spring Valley

Home of the Cardinals

OPTIONAL

SCHOOL DISTRICT OF SPRING VALLEY
FOOD BACKPACK PROGRAM REGISTRATION FORM

The Spring Valley Food Backpack Program is aimed to provide weekend food for families in need. Twice a month backpacks are filled with basic non-perishable food items such as granola bars, canned fruit or vegetables, pasta, jelly or peanut butter. Personal hygiene items are occasionally included as well.

PARENT/GUARDIAN NAME_____

PARENT/GUARDIAN EMAIL _____

PARENT/GUARDIAN CELL PHONE _____

⬜ I would like to pick up the backpack at the school office.
⬜ Elementary ⬜ Middle/High School

⬜ I would like my child(ren) to bring the backpack home (backpacks will be placed in cubby/locker).

STUDENT NAME_____ GRADE_____

STUDENT NAME_____ GRADE_____

STUDENT NAME_____ GRADE_____

STUDENT NAME_____ GRADE_____

Are there any food allergies?
Please indicate only severe allergies for which that type of food is not allowed in the household. **It is the parent/guardian's responsibility to to check all food for allergies/sensitivities.**

Parent/Guardian Signature: _____

Date: _____

Within the last 3 years, have you or anyone in your household moved for any reason?
☐ YES ☐ NO

Are you working or have you ever worked in agriculture in the last three years?
☐ YES ☐ NO

If you answered **NO** to either of these questions, please stop. If you answered **YES**, please continue.

When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States?

Month_____ Year_____

Please check any of the agricultural activities listed below that you have looked for or worked in:

_____ Plant or harvest vegetables or fruits

_____ Canning vegetables or fruits

_____ Detassel corn

_____ Sod farm

_____ Tobacco farm

_____ Planting, pruning or cutting trees

_____ Poultry and/or egg farm

_____ Dairy farm

_____ Duck, turkey, chicken, pork or beef processing plant

_____ Flora culture/gladiola farm

_____ Aquaculture/fish hatcheries

_____ Green house or plant nursery