WHEELER HIGH SCHOOL

587 W 300 N
Valparaiso, IN 46358
219-759-2561
Fax: 219-759-5602
wheeler/union.k12.in.us

NEW STUDENT REGISTRATION PACKET

Parent/Guardian of student enrolling in the Union Township School Corporation must provide the following documentation:

Union Township Residency Verification Information:

- Proof of home ownership.
- Two recent utility bills showing current name and address.
- Copy of lease or rental agreement signed by the landlord.
- If you are residing with a Union Twp. Resident, the home owner is responsible for filling out a Notarized "Affidavit Supporting Residence" form with the Union Twp. School Corporation office.
- Copy of Parent/Guardian Driver's License with your Union Township address.
- Completion of the DOE Form II of Custodial Statement and Agreement Third Party Custody.
- Change of address verification from US Post Office.

Copy of Students':

- Original birth certificate (we will make a copy to keep on file)
- Immunization records.
- Transcript (we will request official copy from previous school)

THIS INFORMATION MUST BE SUBMITTED AT THE TIME OF REGISTRATION

Please contact student's Guidance Counselor for an appointment.

Students last name (A-L)
Mr. Mike Rosta
Ext. 2242
mrosta@union.k12.in.us

Students last name (M-Z)
Mrs. Amanda Gibson
Ext. 2226
agibson@union.k12.in.us

Wheeler High School

Enrollment Information

Please complete all the following information:

STUDENT INFORMATION:

Last Name: _____ Grade: _____

First Name: _____ **STUDENT CONTACT INFORMATION:**

Middle Name: _____ Home Phone: _____

Preferred name: _____ Student's Cell Phone/Carrier: _____/_____

Date of Birth: _____ Gender: ☐ Male ☐ Female Student's email: _____

ADDRESS INFORMATION:

Student's Address: _____ City: _____ State: **IN** Zip: _____

(If P.O Box) Street Address: _____ County: _____

EDUCATION INFORMATION:

Transferring from: School Name: _____ City/State: _____/____

Special Education Requirements:

Does this student have a current IEP (Individualized Education Program)? ☐ Yes ☐ No

Race/Ethnicity: Districts must collect race and ethnicity information on students using a two part question: The respondent must complete both Ethnic and Race sections.

Part 1: Ethnicity (Is the student Hispanic/Latino? Choose only one)

☐ **No**, Not Hispanic/Latino ☐ **Yes**, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Part 2: Race (What is the student's race? (Choose one or more if multiracial)

☐ **American Indian or Alaskan Native:** A person having origins in any of the original peoples of North America and maintaining cultural identification through tribal affiliation or community recognition.

☐ **Asian or Pacific Islander:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.

☐ **Black or African American:** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **White:** A person having origins in any of the original peoples of Europe, Middle East, North Africa, including Hispanic origins.

Home Language Survey: Information is needed by the Indiana Department of Education regarding your child's language background. This information is important in deciding the most suitable education program for your child.

Country of student's birth: _____ Date of first enrollment in USA schools: _____

What is the native language of the student? _____

What language is spoken most often by student? _____

What language(s) is spoken most by the student at home? _____

Note: if a language other than English is indicated, the student is considered to be a language minority student and will have an English proficiency assessment upon enrollment and annually thereafter to measure English proficiency growth.

Student's name: _____ **DOB** _____ **Grade:** _____

GUARDIAN INFORMATION:

Student lives with: ☐ Parents ☐ Father ☐ Mother ☐ Grandparent ☐ Foster Parent ☐ Other

Person Responsible for Book Fees: _____ ☐ Guardianship court papers on file with school

Guardian(s) Email: _____

Main form of WHS communication (Example: grades and important communications)

Guardian(s) Text Address: Cell Phone & Carrier: _____

Text for special alerts (Example; school closings)

Father:

Last Name: _____

First Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____

Mother:

Last Name: _____

First Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____

Guardian (if other than parent):

Relationship: _____

Last Name: _____

First Name: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____

Emergency Contacts: (other than parent/guardian)

Name: _____

Phone #: _____

Relationship: _____

Name: _____

Phone #: _____

Relationship: _____

Name: _____

Phone #: _____

Relationship: _____

Siblings in Union Twp. School Corporation:

Name: _____ Grade:____ Name: _____ Grade:____

Name: _____ Grade:____ Name: _____ Grade:____

Name: _____ Grade:____ Name: _____ Grade:____

Wheeler High School
587 W. 300 N.
Valparaiso, IN 46385
Phone: 219-759-2561
Fax: 219-759-5602

CONSENT TO RELEASE INFORMATION

Transferred from:

School: _____

Address: _____

_____

_____ has entered our school.
Student Name (PRINT)

As a student in the _____ grade.

Please send the following information as soon as possible
[Fax: 219-759-5602 or email: canderson@union.k12.in.us].

- Complete transcript of grades and credits
- Test Scores
- Attendance Record
- Health Record
- Grades in Progress
- Birth Certificate

- IEP (Individual Education Program) (if applicable)

I give permission for the above student's records to be released to Wheeler High School.

_____ _____
Parent/Guardian Signature Date

WHEELER HIGH SCHOOL

EMERGENCY HEALTH PLAN

Student's Name	School	DOB

HEALTH CONCERNS:

Please check any of the following conditions that pertain to this student:

☐ Glasses/Contact	☐ Vision/Hearing	☐ Seasonal Allergies
☐ ADD/ADHD	☐ Migraines/Frequent Headaches	☐ Arthritis/Bone
☐ Kidney/Bladder	☐ Stomach/Bowel issues	☐ Congenital Defects
☐ Heart Conditions	☐ Physical Handicap: _____	

The following conditions must have an **Emergency Plan Form signed** by a physician and on file with the school Nurse. See the school nurse for this form and if you have any questions.

Allergies: ☐ **Food** (Type) _____ ☐ **Medication** (Type) _____ ☐ **Bee Sting**

☐ *Carries Epipen* ☐ *Epipen – kept in the Nurse's office*

☐ **Asthma** ☐ *Carries Inhaler* ☐ *Inhaler – kept in the Nurse's office*

☐ **Diabetes** ☐ **Seizures** (Type) _____

MEDICATIONS: _____

Any health concerns (not listed above): _____

_____

In case of serious illness/injury, I give permission for the above named student to be treated at the nearest emergency room.

Parent/Guardian Signature	Printed Name of Parent or Guardian	Date

My child has my ***permission to take acetaminophen*** (Tylenol-like) at school. I am authorizing this ONE TIME dose to be given to my child:

☐ 1(one) tablet acetaminophen 325mg ☐ 2 (two) tablets acetaminophen 325mg.

Parent/Guardian Signature	Printed Name of Parent or Guardian	Date

UNION TOWNSHIP SCHOOL CORPORATION

CHILDREN AND HOOSIERS IMMUNIZATION REGISTRY PROGRAM CONSENT (CHIRP)

I; _____, give Union Township Schools permission to release the following
Parent/Guardian

information concerning my child; _____to the Indiana State Department
Student's Name

of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

I GIVE PERMISSION FOR THE FOLLOWING INFORMATION TO BE RELEASED:

- **IMMUNIZATION DATA**
- **IDENTIFYING INFORMATION SUCH AS; NAME, DATE OF BIRTH AND ADDRESS.**
- **LIST ANY ADDITIONAL INFORMATION:**_____

_____

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____	_____	_____
Parent/Guardian Signature	Printed Name of Parent or Guardian	Date
_____	(____)_____	
Address	Telephone Number	
_____	_____	_____
Child's Name	School	DOB

UNION TOWNSHIP SCHOOL CORPORATION MEDICATION GUIDELINES

In order to protect the health and welfare of the students and school staff alike, Indiana law requires that parents/guardians consent, in writing, to the administration of both prescription and over-the counter medications. Please read this policy carefully regarding medication administration during school hours.

PRESCRIPTION MEDICATION may only be given to students provided the following is on file at school:

- A written order from the physician OR the prescription bottle labeled with: student's name, name of the medication, dose, frequency, and time.
- **Written authorization from the parent/guardian and reason for medication.**
- The dose, time, and frequency of a prescribed medication may only be changed with a physician order or a new updated prescription label on the bottle.

OVER-THE-COUNTER MEDICATION may only be given to students provided the following is on file:

- Written authorization by the parent and the reason the medication is to be given.
- **Dose, frequency, and time** for which the parent is providing written authorization.
- Over-the counter medications will not be administered in any manner inconsistent with the instructions on the label.

THE SCHOOL **DOES NOT** SUPPLY MEDICATION. MEDICATION MUST BE BROUGHT IN BY A PARENT/GUARDIAN IN AN UNOPENED ORIGINAL CONTAINER (FOR OVER-THE-COUNTER MEDICATION). ALL MEDICATION MUST BE DISPENSED IN THE NURSE'S OFFICE AND WILL BE KEPT IN A LOCKED CABINET.
STUDENTS MUST NOT CARRY MEDICATION IN THEIR PURSES, BACKPACKS, OR POCKETS. MEDICATIONS MUST BE **PICKED UP** AT THE END OF THE YEAR BY A PARENT/GUARDIAN.

THOSE STUDENTS WITH ASTHMA OR LIFE THREATENING ALLERGIES MAY CARRY THEIR OWN EMERGENCY MEDICATIONS, BUT MUST HAVE WRITTEN AUTHORIZATION FROM A PHYSICIAN AND PARENT/GUARDIAN WITH THE STUDENT'S NAME, MEDICATION NAME, DOSE, AND THE INTENT TO CARRY THE MEDICATION. A PHYSICIAN AND PARENT/GUARDIAN MUST CERTIFY THE STUDENT IS CAPABLE OF SAFELY SELF-ADMINISTERING THE MEDICATION IF NECESSARY.

EMERGENCY STOCK MEDICATIONS MAY BE ADMINISTERED TO A STUDENT IF THE STUDENT IS DEMONSTRATING THE SIGNS/SYMPTOMS OF A LIFE-THREATENING EMERGENCY, THE STUDENT DOES NOT HAVE EMERGENCY MEDICATION AT THE SCHOOL, OR THE STUDENT'S PRESCRIPTION IS NOT AVAILABLE.

PRESCRIPTION MEDICATION AUTHORIZATION

All prescription medication will be administered in compliance with Indiana Law and Union Township School Corporation policies.

A written order (a current prescription label is considered a doctor's order) and written authorization of the parent will be required before any prescribed medication may be administered.

All prescription medication must be in the original prescription container and contain the following information:

- Student name
- Medication name
- Dose to be given
- Time to be given

PARENT AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

School_____ Grade _____

Student Name _____ Date of Birth _____

Medication Name _____ Dose _____

Frequency/Time of day _____

Reason medication will be given _____

Parent Authorization:

I authorize the designee of the above school to administer this prescription medication as ordered above. **Note:** In the event there is not a school nurse available, a trained secretary or staff member may administer this medication.

I will assume the responsibility for safe delivery of the medication to school.

I will notify the school nurse immediately if there is any change in the physician order for this medication. I will pick up any discontinued medication.

_____ _____

Parent/Guardian Signature Date

Unused medications must be picked up by the last day of school. Medications may only be released to parent/guardian or a person over 18 with written consent. Medications may be released to high school students only with written parent/guardian consent.

3/24/23

OVER-THE-COUNTER MEDICATIONS CONSENT

All medication dispensed by school personnel will be administered in compliance with Indiana State Law and Union Township School Corporation guidelines.

All non-prescription (over-the-counter) medications to be given at school MUST meet the following criteria:

- Send medicine in the original manufacturer's container. The school does not provide over-the-counter medications.
- The authorization below must contain the following information:
  - Name of the student
  - Name of the medication
  - Dose (exact) to be given (e.g. number of tablets)
  - Frequency (how often can medication be given during school day)
  - Reason medication is to be given

AUTHORIZATION TO ADMINISTER MEDICATION

School_____

Student Name _____ Date of Birth _____ Grade ____

Medication Name _____ Dose _____

Frequency (how often medication can be given) _____

Reason medication will be given _____

Parent Authorization:

I authorize the designee of the above school to administer this medication as requested above.

Note: In the event there is not a school nurse available, a trained secretary or staff member may administer the medication.

_____ _____

Parent/Guardian Signature Date

Medications must be picked up by the last day of the year. Medications may only be released to parent/guardian or a person over the age of 18 with written consent. Medications may be released to high school students only with written parent/guardian consent.

3/24/23