

REGISTRATION/EMERGENCY FORM 2020-2021

School District of Bonduel
400 W. Green Bay St. • PO Box 310 • Bonduel, WI 54107

PRINT STUDENT'S LEGAL NAME

Last _____ First _____ Middle _____ (Nickname _____)
Date of Birth ____/____/____ Age _____ Check One: Male _____ Female _____
City & State of Birth _____ County of Birth _____
Residence Address _____
Mailing Address _____
City _____ State _____ Zip _____ Current Township _____
Home Phone (____) _____

ETHNIC BACKGROUND (Required by DPI) Check One:

____ White/Non-Hispanic (WNH) ____ Black/Non-Hispanic (BNH) ____ Alaskan Native/Indian-American (AIN)
____ Hispanic (HIS) ____ Asian/Pacific Islander (API)

LANGUAGE(S) other than English spoken in the home: _____

NAME/S OF PARENT/S OR GUARDIAN/S STUDENT IS LIVING WITH:

1. Last _____ First _____
Relationship (eg., mom, dad, step-mom, step-dad, legal guardian, etc.) _____
Employer _____ City, State _____
Work No. (____) _____ Cell Phone (____) _____
PARENT/GUARDIAN Home E-mail: _____ **Work Email:** _____

2. Last _____ First _____
Relationship (eg., mom, dad, step-mom, step-dad, legal guardian, etc.) _____
Employer _____ City, State _____
Work No. (____) _____ Cell Phone (____) _____
PARENT/GUARDIAN Home E-mail: _____ **Work Email:** _____

Legal Custody belongs to: _____ Both _____ Mother _____ Father _____

PARENTS/GUARDIAN DIVORCED - Name of Parent Child is **NOT** living with: (Release information: Yes _____ No _____)

Last _____ First _____
Relationship (eg., mom, dad, step-mom, step-dad, legal guardian, etc.) _____
Residence Address _____ Mailing Address _____
City _____ State _____ Zip _____ Home Phone (____) _____
Parent/Guardian E-mail _____

FAMILY PHYSICIAN: _____ Phone # (____) _____ City, State _____

FAMILY DENTIST: _____ Phone # (____) _____ City, State _____

MEDICAL ALERTS: Please list any concerns of which school personnel should be aware of: (e.g. allergy to bee stings, seizure disorders, diabetes). Please specify: _____

Medications: _____

Is there any other information about your child and/or family that the school needs to know (please explain): _____

I hereby authorize school personnel to call a physician, dentist, or emergency vehicle if an emergency exists. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. I understand that this information will be shared with all school personnel that need to know this information to protect the life and safety of said child.

I further authorize emergency treatment to be initiated at the medical facility to which my child is transported. I do hereby indemnify and hold harmless the physician, hospital and other persons who act in reliance upon this authorization.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

(CONTINUED ON BACK)

(Continued from front Page)

Last _____ First _____ Middle _____ (Nickname _____)
Date of Birth ____/____/____

Frequently when children become seriously ill or injured, we find it difficult to locate parents or legal guardians for immediate action. Please list several alternate contact/s that we can notify in the local area in case we are unable to reach either mother, father or legal guardian.

ALTERNATE CONTACT/S:

1. Last _____ First _____
Relationship to Child _____
Residence Address _____ City, State _____
Phone No. (____) _____ Work No. (____) _____ Cell Phone (____) _____

2. Last _____ First _____
Relationship to Child _____
Residence Address _____ City, State _____
Phone No. (____) _____ Work No. (____) _____ Cell Phone (____) _____

FOR OFFICE USE ONLY (fill in those which apply)

Entry Date _____ Bus # _____ Mileage _____
Locker _____ Homeroom _____ Check Township _____
Date Entered into WSLs _____

PLEASE PROVIDE PARENT AND GUARDIAN EMAIL ADDRESSES.

This will enable you to receive food service lunch balance alerts, automated information alerts from the School District, and easier communication between your child's teacher(s).

HOME LANGUAGE SURVEY
Information about the language spoken in the home.

Student Name _____

School _____ Grade _____ Teacher _____

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 | Spanish | Other |
|---|--------------------------|--------------------------|-------|
| 1. What language did the child learn when she or her 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 his/her child most of the time? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. What language does the child speak to his/her parents 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 his/her siblings most of the time? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. What language does the child speak to his/her 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"/> | |
| Can they read English? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Do the parents/guardians request oral and/or written communication from the school to be in English, Spanish, or another language? _____ | | | |

Signature

Date



School District of Bonduel
400 West Green Bay Street • Bonduel, WI 54107



STUDENT SCREENING FORM

STUDENT: _____ D.O.B. _____ GRADE: _____

PARENTS: _____ PH #: _____

ADDRESS: _____

Date of Entry: _____ Previous School : _____

Street Address: _____

City/State/Zip: _____

Please answer the following questions regarding your child's educational history.

1). Has your child received special services? Circle yes or no for each of the categories below:

Autism	Yes	No	<u>Related Services:</u>		
Traumatic Brain Injury	Yes	No	Occupational Therapy	Yes	No
Cognitive Disability	Yes	No	Physical Therapy	Yes	No
Learning Disability	Yes	No	Adaptive Physical Education	Yes	No
Hearing Impairment	Yes	No	<u>Other:</u>		
Visual Impairment	Yes	No	Remedial Reading Services	Yes	No
Speech or Language Delays	Yes	No	Title I Reading	Yes	No
Emotional Disturbance	Yes	No	Title I Math	Yes	No
Orthopedic Impairment	Yes	No	Gifted and Talented Services	Yes	No
Other Health Impairment	Yes	No	At-Risk Programing	Yes	No
Significant Delevopmental Delay	Yes	No	Alternative School Programing	Yes	No

2). Does your child have academic/behavioral/or social problems that are of concern to you?
If so, please explain: _____

3). Has your child ever repeated a grade. Yes No (If yes, which grade?): _____

4). Has your child ever been recommended to repeat a grade? Yes No (If yes, which grade?): _____

5). Does your child have any health problems that could interfere with the learning process? Yes No
(If yes, please explain): _____

6). Is your child taking any medication that should be known to the school? Yes No
(If yes, please explain): _____

Parent Guardian Signature

Date

Bonduel School District – Student Bus Registration

Parents/guardians must complete this form in order for your child to be transported.

Whenever pick up or drop off points change, a new form must be submitted.

Please complete this form **FOR EACH STUDENT** who is eligible for transportation from home to school, and/or from school to home **EVEN IF THEY WILL NOT BE RIDING THE BUS.** To create efficient bus routes and to reduce the wasteful expense of “unused” busing, it is necessary to discern who WILL and who WON’T need bus transportation. If your child needs busing at a later time, he/she can be added to the bus route. Allow 3 business days for changes to the bus route to take effect. Changes may affect the pick-up and drop-off times of existing bus routes. **Please email the bus garage with any questions: michelle.bunker@kobussen.com or call: 715-280-3001 Option 1**

Student Information		Transportation to begin (check box) <input type="checkbox"/> Start of School Year <input type="checkbox"/> On (enter date) / /
Student Name	School Name (2020-21 School Year)	Grade (2020-21 School Year) Birthdate
Pick Up Location (circle only 1)	NO RIDE NEEDED HOME OTHER	
Drop Off Location (circle only 1)	NO RIDE NEEDED HOME OTHER	
Medical or useful information about student		
Family Information		
Physical Home Address (including city):		Mailing Address if Different:
Parent/Guardian Name	Relationship to Student	Phone Alternate Phone
Parent/Guardian Name	Relationship to Student	Phone Alternate Phone
Emergency Contact Name	Relationship to Student	Phone Alternate Phone
Daycare (Alternate Bus Stop Request)	Parents may designate no more than ONE alternate child care location for pick up and/or ONE alternate location for drop-off. IMPORTANT: The request must be consistent every day, and located within the school district.	
Physical Address of Alternate Stop		Daycare Notes
Child Care Provider Name	Phone	Alternate Phone
Parent Guardian Signature:		Date:
Office Use Only:	Skyward ID#	AM Rt. # Pick Up Time: PM Rt. # Drop off Time: