



# Bonduel Elementary School

400 W. Green Bay St.  
P.O. Box 310  
Bonduel WI 54107  
Phone: 715-758-4850 Ext. 2

## Request For Transfer of Student Records

Date: \_\_\_\_\_

School Requesting Records From: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Student Name	Grade	Date of Birth

In Compliance with Final Regulations-Family Education Rights and Privacy Act, dated June 17, 1976, which states that it is no longer necessary to obtain written consent to release records between school systems, we are requesting the following information.

- Progress records pertinent to grades, attendance, extra-curricular activities
- Behavioral records, including psychological testing, personality evaluations, test relating to achievement or measurement of ability.
- Permanent health records
- All Special Education Records

Transfer of Records: Within 5 working days, a school district shall transfer to another school or school district all pupil records relating to a specific pupil if the transferring school district has received written notice from the pupil if he or she is an adult or his or her parent or guardian if the pupil is a minor that the pupil intends to enroll in the other school or school district, or written notice from the other school or school district that the pupil has enrolled.

**PLEASE FAX CURRENT IEP TO: 1-715-997-3190**  
**or email: [dowdemel@bonduel.k12.wi.us](mailto:dowdemel@bonduel.k12.wi.us)**

**Please send records to:**

**BONDUEL ELEMENTARY SCHOOL**  
**P.O. BOX 310**  
**BONDUEL, WI 54107**

**Or email: [borowmon@bonduel.k12.wi.us](mailto:borowmon@bonduel.k12.wi.us)**

**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	<b><u>Related Services:</u></b>		
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	<b><u>Other:</u></b>		
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](mailto:michelle.bunker@kobussen.com) or call: 715-280-3001 Option 1**

<b>Student Information</b>		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		
<b>Family Information</b>		
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. <b>IMPORTANT:</b> 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: