REGISTRATION/EMERGENCY FORM 2025-2026

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) Circle One:
_____ White/Non-Hispanic (WNH) ____ Black/Non-Hispanic (BNH) _____Alaskan Native/Indian-American (AIN)
_____ Hispanic (HIS) ____Asian/Pacific Islander (API) Tribal Affiliation _____

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 (_____)_____

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).

FOR OFFICE USE ONLY (fill in those which apply)
Entry Date _____ Bus #_____ Mileage _____
Locker _____ Homeroom _____ Check Township _____
Date Entered into WiseData_____