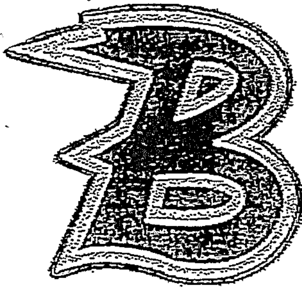


Bonduel Elementary School

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

Please send records to:

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

Or email: borowmon@bonduel.k12.wi.us

Birth Certificate Verification Form

Please display the information exactly as its listed on the birth certificate.

PLEASE PRINT CLEARLY. (The Birth Certificate will need to be brought to the office for office personnel to verify the bottom portion of this form)

Student Name Spelling:

Last:____________________ First:____________________ Middle:____________

Date of Birth: ____________________ Gender: Female / Male

Place of Birth: ____________________ ____________________

City State

Mother's Name: Last____________________ First:____________________ Middle:____________

Date of Birth: ____________________

Mother's Current Last Name if Different than on the Birth Record:____________________

Father's Name: Last____________________ First:____________________ Middle:____________

Date of Birth: ____________________

____________Information below to be completed by Office Staff only____________

Verified by: ____________________ Date:____________________

Document#____________________

3K
REGISTRATION/EMERGENCY FORM 2024-2025

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

Instructions: The parent/guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that the parents/guardians and center staff periodically review and update the information provided on this form.

PRINT STUDENT'S LEGAL NAME
Last ____________________ First ____________________ Middle __________ (Nickname __________)
Date of Birth _____/_____/_____ Age______ Check One: Male_____ Female_____ First Day of Attendance: __________
Residence Address ______________________________ City______________ State_____ Zip code__________
Mailing Address ____
City & State of Birth ____________________ County of Birth ____________________
Current Township ____________________ School district residing in ____________________

ETHNIC BACKGROUND 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 – All parents/guardians are permitted to visit during school hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the depart recommends the provider obtain and attach a schedule.

1. Last ____________________ First ____________________
Relationship (e.g., mom, dad, stepmom, stepdad, legal guardian, etc.) ____________________
Employer ____________________ City, State ____________________
Work No. (_____) ____________________ Cell Phone (_____) ____________________
PARENT/GUARDIAN Home E-mail: ____________________ **Work Email:** ____________________
2. Last ____________________ First ____________________
Relationship (e.g., mom, dad, stepmom, stepdad, 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 (e.g., mom, dad, stepmom, stepdad, legal guardian, etc.) ____________________
Residence Address ______________________________ City______________ State_____ Zip code__________
Mailing Address ____
Employer ____________________ City, State ____________________
Work No. (_____) ____________________ Cell Phone (_____) ____________________
PARENT/GUARDIAN Home E-mail: ____________________ **Work Email:** ____________________

EMERGENCY CONTACT/S – The person to be notified in an emergency when parents/guardians cannot be reached.
1. Last ____________________ First ____________________
Relationship to Child ____________________
Residence Address ____________________ City, State ____________________
Phone No. (_____) ______________ Work No. (_____) ______________ Cell Phone (_____) ______________

Is this person authorized to pick up child: Yes ____ No ____

2. Last ____________________ First ____________________
Relationship to Child ____________________
Residence Address ____________________ City, State ____________________
Phone No. (_____) ______________ Work No. (_____) ______________ Cell Phone (_____)______________
Is this person authorized to pick up child: Yes ____ No ____

AUTHORIZED PERSONS – Persons other that parents/guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

1. Last ______________________ First ______________________
Relationship (Grandparent, Aunt, Uncle, etc.) ______________________
Employer ______________________ City, State ______________________
Work No. (____) ______________________ Primary Phone (____) ______________________
E-mail address where reachable while child in care: ______________________

2. Last ______________________ First ______________________
Relationship (Grandparent, Aunt, Uncle, etc.) ______________________
Employer ______________________ City, State ______________________
Work No. (____) ______________________ Primary Phone (____) ______________________
E-mail address where reachable while child in care: ______________________

PHYSICIAN OR MEDICAL FACILITY

FAMILY PHYSICIAN: ______________________ Phone # (____) ______________
Address ______________________ City ______________ State _____ Zip Code ___________

WEB CONSENT (Please circle YES or NO)

Key points in Bonduel School District policy KBCG regarding publishing of student information:

*Signed permission slip from parents/guardian and student allowing use must be obtained prior to publishing student names, pictures, videos, voice, or work samples
*Student names will appear as first name and last initial in all public access areas of website
*Parent/guardian or student can revoke permission once granted by written request
*Permission can be granted or revoked in three categories: student name, picture, work samples
*Not granting permission will result in student from being excluded from school bulletins or school newspapers as those are published to the web site

YES	I give my permission to allow the use of pictures of student (still or video), student's work samples (including voice recordings), and student name to be published on the School District of Bonduel website.
NO	I do not grant permission to allow the use of pictures of student (still or video), student's work samples (including voice recordings), and student name to be published on the School District of Bonduel website.

AUTHORIZATIONS (Please circle YES or NO)

YES	NO	I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
YES	NO	I have had an opportunity to review the policies of this childcare center and a summary of the Wisconsin Rules for Licensing Child Care Centers. (This is on our district website under the 3K Program)
YES	NO	I give permission for my child to participate in transported and/or walking field trips and other activities during operating hours.
YES	NO	I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

PARENT/GUARDIAN SIGNATURE: ______________________ **DATE:** ___________

REGISTRATION/EMERGENCY FORM

Instructions: The parent/guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents/guardians and center staff periodically review and update the information provided on this form.

Last ____________________ First ____________________ Middle __________
Address ________________________________ City ____________ State ______ Zip Code ____________
Date of Birth ______/______/______ Age ______ First Day of Attendance: __________

PARENT/GUARDIAN INFORMATION- Provide information where the parent(s)/guardian(s) may be reached while the child is in care.

1. Last ____________________ First ____________________ Home Phone (____) ______________
Work No. (____) ____________________ Cell Phone (____) ____________________

2. Last ____________________ First ____________________ Home Phone (____) ______________
Work No. (____) ____________________ Cell Phone (____) ____________________

PHYSICIAN/MEDICAL FACILITY INFORMATION

FAMILY PHYSICIAN: ____________________ Phone # (____) ______________
Address ________________________________ City ____________ State ______ Zip Code ____________

FAMILY DENTIST: ____________________ Phone # (____) ______________
Address ________________________________ City ____________ State ______ Zip Code ____________

EARLY DISMISSAL

In the event that schools are closed prior to the regular dismissal time, please choose one of the options listed below.
(1) Have my child ride their normal bus. (2) I will pick up my child. (3) Other - Please list.

Option chosen: ____

HEALTH HISTORY AND EMERGENCY CARE PLAN-If available, attach any health care plan information from the child's physician, therapist, etc.

1. **Check any special medical condition that your child may have.**
   ___ **No specific medical condition**
   ___ **Asthma**
   ___ **Diabetes**
   ___ **Gastrointestinal or feeding concerns including special diet and supplements**
   ___ **Cerebral palsy/motor disorder**
   ___ **Epilepsy/seizure disorder**
   ___ **Milk Allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.**
   ___ **Food allergies**
   ___ **Non-food allergies – Specify below.**

2. **Triggers that may cause problems – Specify below.**

3. **Signs or symptoms to watch for – Specify below.**

Continue on next page

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form Authorization to Administer Medication should be attached to this form. Note: Group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training/instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care of reassessment.

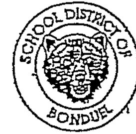
8. Additional information that may be helpful to the child care provider.

PARENT/GUARDIAN SIGNATURE: ______________________________ DATE: __________

Review dates: __________ __________ __________ __________ __________

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	Related Services:		
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	Other:		
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

White: Cumulative Folder/School Office Yellow: Pupil Services Office

Part I: Ethnicity Designation

Is the person Hispanic or Latino? Must choose one.

- ☐ Hispanic or Latino *[If selected go to Question I-A]*
- ☐ Not Hispanic or Latino *[If no, go to Question Part II]*

Optional Question I-A: If Hispanic or Latino was chosen above, select all that apply from the list below:

☐ Columbian	☐ Ecuadorian	☐ Guatemalan
☐ Mexican	☐ Puerto Rican	☐ Salvadoran
☐ Spaniard/Spanish/Spanish-American		☐ Decline to indicate
☐ Unknown	☐ Other	

Part II: Race Designation

Select one or more of the following categories that apply to this person:

☐ American Indian or Alaska Native *[If selected go to question II-A]*

Optional Question II-A: If chosen, select all that apply from the list below:

☐ Bad River Band	☐ Forest County	☐ Ho-Chunk
☐ Lac Courte Oreilles	☐ Lac du Flambeau	☐ Menominee
☐ Oneida Nation (Wisconsin)	☐ Red Cliff	☐ Sokaogon
☐ St. Croix	☐ Stockbridge	☐ Brothertown

☐ Other *Please select value form Tribal Affiliation List* ____________________

☐ Asian *[If selected go to question II-B]*

Optional Question II-B: If chosen, select all that apply from the list below:

☐ Burmese	☐ Chinese	☐ Filipino
☐ Hmong	☐ Indian	☐ Karen
☐ Korean	☐ Vietnamese	☐ Decline to indicate
☐ Unknown	☐ Other	

☐ Black or African American *[If selected go to question II-C]*

Optional Question II-C: If chosen, select all that apply from the list below:

☐ African-American	☐ Ethiopian-Oromo	☐ Ethiopian-Other
☐ Liberian	☐ Nigerian	☐ Somali
☐ Decline to indicate	☐ Unknown	
☐ Other		

☐ Native Hawaiian or Other Pacific Islander

☐ White

HOME LANGUAGE SURVEY

Information about the language spoken in the home

Student Information	
First Name:	Date of Birth:
Last Name:	School: BES / JR HIGH / BHS

Questions for Parents or Guardians	√ Check one
What is the language most frequently spoken at home? ¿Cuál es el idioma que se habla con más frecuencia en casa?	◯ English/Inglés ◯ Spanish/Español ◯ Other/Otros
What language did your child learn when he/she began to talk? ¿Qué idioma aprendió su hijo cuando comenzó a hablar?	◯ English/Inglés ◯ Spanish/Español ◯ Other/Otros
Which language does your child most frequently speak at home? ¿Qué idioma habla su hijo con más frecuencia en casa?	◯ English/Inglés ◯ Spanish/Español ◯ Other/Otros
Which language do you most frequently speak to your child? ¿Qué idioma le habla con más frecuencia a su hijo?	◯ English/Inglés ◯ Spanish/Español ◯ Other/Otros

Parent Preferences	
In what language would you prefer to get information from school? ¿En qué idioma preferiría obtener información de la escuela?	◯ English/Inglés ◯ Spanish/Español ◯ Other/Otros

Child Health Report – Child Care Centers

Use of form: Use of this form is required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. Completion of this form meets the requirements of DCF 202.08 (4), DCF 250.04 (6) (a) 4. and DCF 251.04 (6) (a) 8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

Child's Name (Last, First, MI)	Child's Birthdate (mm/dd/yyyy)

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

Parent or Guardian Address (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes," identify the recommended milk substitute.

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's most recent blood lead test: ____________ (mm/dd/yyyy).
Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA, or other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 6/2020)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN **30 DAYS AFTER ADMISSION.** State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1 **PERSONAL DATA** **PLEASE PRINT**

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE MM/DD/YYYY	SECOND DOSE MM/DD/YYYY	THIRD DOSE MM/DD/YYYY	FOURTH DOSE MM/DD/YYYY	FIFTH DOSE MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine *Vaccine is required only if your child has not had chickenpox disease. See below:*					

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:
☐ YES ______ Year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
If YES, provide laboratory report(s)

Step 3 **REQUIREMENTS**

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4 **COMPLIANCE DATA**

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

— Or —

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETELY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has **NOT** received **ALL** the required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: **Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.**

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations ______________________

______________________ ______________________
SIGNATURE - Physician Date Signed

☐ **For religious reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

Step 5 **SIGNATURE**

This form is complete and accurate to the best of my knowledge. Check one: (**I do** ☐ **I do not** ☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

______________________ ______________________
SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

Tell Me About Your Child

Student's Name:____

Parent Name(s): ____

Hello 3K Families!

You are your child's first, best, and most powerful teacher! We will be your partner this year in providing a play-based introduction to school. We believe that every child can learn, but that not all children learn in the same way. Any insights you can share will help us tailor our approach to serve your child in the way he or she best learns. Please use this informal survey to answer only those questions for which you are comfortable sharing information with us. We will apply it in our planning to make sure your child gets the unique and specific instruction that will make this a great first year of school!

Thank you,

The Bonduel Elementary 3K Team

1. How do you describe your child's personality?

2. Tell us about any special interests, toys, or characters your child enjoys.

3. What do you consider your child's strengths?

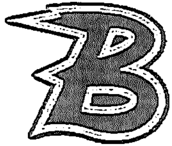
4. What do you feel your child needs help with?

5. When not in school, how does your child spend most of his/her time?

6. Does your child have siblings?

7. Are there fear, health, or behavioral concerns you want us to know about?

8. Is there anything else you would like to share with us?



SDOB BUS TRANSPORTATION REQUEST FORM

Please complete this form if your child is eligible for transportation from home to school, and/or from school to home. 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 transportation for the school year. <u>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.</u> Changes may affect the pick-up and drop-off times of existing bus routes.

Student Last Name: ______________________________ Student First Name: ____________________

Grade Entering 2024-25: ______

Will your child need bus transportation for school? (Circle one) YES / NO

If you selected 'YES' please enter pickup and drop off locations. If you selected 'No' please select 'NONE' for your answers to complete the form. **If you choose Babysitter/Other please contact the Kobussen Bus Company at 715-280-3001, Option 1 to discuss your busing options with a representative.**

Pickup Site Request: (Please circle)

None / Home Residence / Bear Cubs Daycare / Baby sitter/Other

Drop off Site Request: (Please circle)

None / Home Residence / Bear Cubs Daycare / Baby sitter/Other

If your child will NOT be using bus transportation after school, how will your child go home?

Walker / Pickup / Other

Parent/Guardian Signature: ____________________________________ Date: __________________

Relationship to Student: ______________________________

OFFICE USE ONLY	Skyward number: