School District of Wausaukee

Every Student, Every Day

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Dear parent(s) and/or guardian(s),

Now that your student is making his or her way into 4K, it is a policy of the Wausaukee School District to request and obtain a well child check (physical) and encourage an eye/dental examination. Please have the attached forms completed by the first day of school. If you are unable to, please have forms back by the second Monday of October.

Please be aware that the Wisconsin Immunization Law requires a few vaccinations when starting 4k. In the event of uninsured children, please call Marinette County Health Department as they may be able to help (715-732-7670). Children with insurance coverage for vaccines may obtain their vaccines through their medical provider. If you choose not to immunize your child, waivers are available for religious, health, or personal conviction reasons. However, if an outbreak were to occur, for your child's safety, the district may exclude them from in-person learning until the outbreak subsides.

Within these walls, we understand that some children may have underlying conditions or allergies that create challenges and risks. If this is your child, please contact me at any time so a plan can be put into place. Once this information is known, form(s) will be sent home to ensure your student gets the appropriate care needed.

On behalf of the district, we welcome your child to the Wausaukee School District and we can not wait to watch your child grow throughout the years ahead. Feel free to contact me with any questions.

Thank you,

Liana Richardson CMA, HA
Certified Medical Assistant/ Health Aide

HEALTH EXAMINATION

	Date	Results
Hemoglobin/Hct		
Urinalysis		
Tuberculin (PPD)		mm
Chest x-ray		
Lead		

Height: _____ins.

Weight: _____ lbs.

Blood Pressure ___/___

Hearing: ___Normal ___Abnormal

Hearing aid(s): ___yes ___no

Vision: R 20/___ L 20/___

Corrected ___Yes ___No

	Normal	Abnormal
Ears		
Mouth / Dental		
Throat		
Nose		
Lymph Nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Musculoskeletal		
Spine		
Extremities		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Behavior		
Speech		

Describe any abnormal findings / chronic conditions.

Health Concerns	Recommendations for School

Note: A separate medication form is required for all medications and treatment to be administered at school.

Signature and title of health care provider _____ Print name _____ Date of physical exam _____

Clinic name _____ Phone _____ FAX _____

Please return this form to your school nurse.

The school district intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. (MS Section 13.04, Subdivision2) 2/27/08

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Pre-K/Kindergarten Dental Examination Form

Name:_____ **Age:**_____ **DOB:**_____

Has this child received any previous dental care?.....Yes No

Is oral health satisfactory?.....Yes No

Any other abnormalities?..... Yes No

Is child brushing satisfactorily?..... Yes No

Recommendations:_____

Codes: C-Cavity F-Filling M-Missing A-Abscess

3	4	5	6	7	8			9	10	11	12	13	14
	A	B	C	D	E			F	G	H	I	J	

R_____L

	T	S	R	Q	P			O	N	M	L	K	
30	29	28	27	26	25			24	23	22	21	20	19

Dentist Name/Phone:_____

Signature of Dentist:_____ Date:_____

State of Wisconsin
Department of Regulation and Licensing

KINDERGARTEN EYE HEALTH EXAMINATION REPORT

Student's Name _____ Birth Date _____ Sex _____

Parent or Guardian _____ Phone _____

Address _____ County _____

School/Kindergarten _____ City _____

Date entering Kindergarten _____

The State of Wisconsin encourages parents of Kindergartners to arrange for their child's eyes to be examined by an optometrist or evaluated by a physician by December 31 of the child's first year in school. An examination or evaluation should include, at a minimum, the elements listed below. (By checking the box, the examining doctor is indicating that the element checked was performed.)

- ☐ Brief history (general health and eye health) of the child, including family history
- ☐ General external observation of the child's eyes and surrounding structures
- ☐ Ophthalmoscopic examination through an undilated pupil
- ☐ Gross measurement of peripheral vision
- ☐ Evaluation of eye coordination and function (alignment and motility)
- ☐ Visual acuity for each eye (separately)

Findings:

As a result of this examination, follow-up care for the child is recommended: ☐ Yes ☐ No

Date of examination:

_____

Doctor/Physician Signature:

_____

Print or stamp:
Doctor/Physician Name
Address
Phone

IMPORTANT NOTICE TO PARENTS

This examination is not required by law. Disclosure of the information noted above is necessary to comply with the statutory purpose as outlined in s. 118.135, Wis. Stats.

Disclosure of this information is voluntary and there is no penalty for non-compliance.

You are encouraged to provide a copy of this form to the school and keep a copy for your record.

Consent of parent or guardian: I agree to release the above information on my child to appropriate school authorities and consent to my child obtaining an eye examination.

Signature _____

Date _____

#2540 (2/02)
s. 118.135, Stats.

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

STUDENT IMMUNIZATION LAW
AGE/GRADE REQUIREMENTS

The following are the minimum required immunizations for each age and grade level according to the Wisconsin Student Immunization Law. These requirements can be waived for health, religious, or personal conviction reasons. Additional immunizations may be recommended for your child depending on his or her age. Please contact your doctor or local health department to determine if your child needs additional immunizations.

Grade/Age	Number of Doses					
Pre-K (ages 2 through 4 yrs)[1]	4 DTaP/DTP/DT[2]		3 Polio	3 Hepatitis B[6]	1 MMR[7]	1 Varicella[8]
Kindergarten through Grade 5	4 DTaP/DTP/DT/Td[2,3]		4 Polio[5]	3 Hepatitis B[6]	2 MMR[7]	2 Varicella[8]
Grades 6 through 12	4 DTaP/DTP/DT/Td[2]	1 Tdap[4]	4 Polio[5]	3 Hepatitis B[6]	2 MMR[7]	2 Varicella[8]

1. Children 5 years of age or older who are enrolled in a Pre-K class should be assessed using the immunization requirements for Kindergarten through Grade 5, which would normally correspond to the individual's age.
2. D = diphtheria, T = tetanus, P = pertussis vaccine. DTaP/DTP/DT/Td vaccine for all students Pre-K through 12: Four doses are required. However, if a student received the 3rd dose after the 4th birthday, further doses are not required. **Note**: A dose four days or less before the 4th birthday is also acceptable.
3. DTaP/DTP/DT vaccine for children entering Kindergarten: Each student must have received one dose after the 4th birthday (either the 3rd, 4th, or 5th dose) to be compliant. **Note**: a dose four days or less before the 4th birthday is also acceptable.
4. Tdap is an adolescent tetanus, diphtheria, and acellular pertussis combination vaccine. If a student received a dose of a tetanus-containing vaccine, such as Td, within five years before entering the grade in which Tdap is required, the student is compliant and a dose of Tdap vaccine is not required.
5. Polio vaccine for students entering grades Kindergarten through 12: Four doses are required. However, if a student received the 3rd dose after the 4th birthday, further doses are not required. **Note**: a dose four days or less before the 4th birthday is also acceptable.
6. Laboratory evidence of immunity to hepatitis B is also acceptable.
7. MMR is measles, mumps, and rubella vaccine. The first dose of MMR vaccine must have been received on or after the 1st birthday. Laboratory evidence of immunity to all three diseases (measles and mumps and rubella) is also acceptable. **Note**: A dose four days or less before the 1st birthday is also acceptable.
8. Varicella vaccine is chickenpox vaccine. A history of chickenpox disease or laboratory evidence of immunity to varicella is also acceptable.