Dear 4K & 5K Parents/Guardians,

As we partner with families to provide a safe and learning environment for your child, it is important we have some medical issues addressed before your child's first day of school. Please take some time to review the information. Understand this information is separate from the online registration which will take place later this summer.

Health Records: In order to establish a strong foundation of your child's health needs, it is important we obtain health records completed by your child's primary care provider to understand those needs. A physical exam, eye exam and dental exam are highly recommended before entering the school setting, and serve as a basis in the event of any physical or medical problems the child may have that require attention and monitoring in the academic setting.

Immunizations: The Wisconsin Immunization Law requires your child receive the following required immunizations when enrolling in any Wisconsin school. These include:

Age/Grade	Number of Doses				
Pre K (2 yrs through 4 yrs)	4 DTP/DTaP/DT	3 Polio	3 Hep B	1 MMR	1 Var
Kdg through 5th grade	4 DTP/DTaP/DT/Td	4 Polio	3 Hep B	2 MMR	2 Var

*For more information, visit our website: http://www.winneconne.k12.wi.us/families/Health-Services.cfm

As the District School Nurse, I am able to obtain your child’s immunization information if it is available on the Wisconsin Immunization Registry. For this reason, I ask you only submit a copy of your child’s immunization records if your child is from out of state or out of the country, is not listed on the Wisconsin Immunization Registry, or you have chosen to opt out of immunizations and will complete a waiver form. Waiver forms are available for religious, health and personal conviction reasons. Please contact me to request this form. Keep in mind that in the event of an outbreak of a vaccine preventable disease, students with waivers may be excluded from school until the outbreak subsides.

If your child has any medical condition(s) that may require a health care plan and/or if your child will need to take medication at school, please inform me. There are a few steps involved with this process and I would like to review them with you.

Thank you so much for your time, patience and understanding. Any additional questions and/or concerns pertaining to your child’s health needs can be directed to me. I can be reached by phone at (920) 582-5803 ext 3134 or by email at krausej@w-csd.org.

Sincerely,

Mrs. Krause, BSN, RN
District School Nurse

Winneconne Community School District

PHYSICAL EXAMINATION RECORD

PARENT OR GUARDIAN – Complete this section

Name – Child (Last, First, MI)	Birth date – Child (mm/dd/yyyy)	Gender – Child

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code) *If different than child*

HEALTH PROFESSIONAL – Complete this section

Allergies – Please list (food, medication, insect)

Medication – Please list all prescribed or any taken on a regular basis

Vision Screening R 20/_____ L 20/_____ Referred Yes_____ No_____	Hearing Screening R ear ________ L ear _________	
TB Skin Test (Recommended for children in high risk groups) Date Read _________ Result _______ mm	Height	Weight

	Normal	Comments/follow up/Needs		Normal	Comments/follow up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes			Genitourinary		
Cardiovascular			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Nutrition		
Cardiovascular			Mental Health		
Respiratory			Other		

****Immunizations** – Required by Wisconsin Immunization Law upon entrance to any Wisconsin school. Waivers are available for religious, health and personal conviction reasons.

Please list any medical conditions the school personnel need to know (epilepsy, diabetes, fainting, allergies, other).

Please list any physical limitations or school activity restrictions.

Please list any history of major surgery or illness that may have impact on learning and/or physical activity.

Does the child have any emotional or behavioral problems with which the school personnel should be concerned?
Yes___ No___ Explain

Physician's recommendation/comments/concerns for school

AUTHORIZATION. I certify that I have examined the above child on this date and that he/she may participate in school activities.

Name of Physician	Office (Name of Clinic, City, Zip Code)	Signature of Physician	Date of Examination

**Only submit immunization records if your child is from out of state or country, NOT listed on the Wisconsin Immunization Registry or you have a signed waiver form. Contact the school nurse for any questions (920) 582-5803 ext 3134.

Winneconne Community School District

EYE HEALTH RECORD

PARENT OR GUARDIAN – Complete this section

Name – Child (Last, First, MI)	Birth date – Child (mm/dd/yyyy)	Gender – Child

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code) *If different than child*

HEALTH PROFESSIONAL – Complete this section

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
- ☐ Opthalmoscopic 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

AUTHORIZATION. I certify that I have examined the above child on this date.

Name of Physician	Office (Name of Clinic, City, Zip Code)	Signature of Physician	Date

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, Wisc. 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.

Parent or Guardian signature	Date

Winneconne Community School District

DENTAL HEALTH RECORD

PARENT OR GUARDIAN – Complete this section

Name – Child (Last, First, MI)	Birth date – Child (mm/dd/yyyy)	Gender – Child

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code) *If different than child*

DENTIST – Complete this section

I have performed a dental examination for the above named student and:

_____ All necessary dental work has been completed
_____ Treatment is in progress
_____ No dental work is necessary
_____ Dental treatment is necessary but no plans for corrections have been made

Dentist's recommendation/comments/concerns for school

AUTHORIZATION. I certify that I have examined the above child on this date.

Name of Dentist	Office (Name of Clinic, City, Zip Code)	Signature of Dentist	Date

PARENT OR GUARDIAN – Complete this section for additional options

❑ An appointment date has been made for ____________________ with Dr.____________________________

❑ My child will be seen by Smiles 4 Life through the Winneconne Community School District
Contact the school nurse for more information (920) 582-5803 ext 3134

Parent or Guardian signature	Date