McFARLAND SCHOOL DISTRICT
Meeting the needs of every learner, every day.

5101 Farwell St. McFarland, WI 53558
(608) 838-4500
www.mcfarland.k12.wi.us

KINDERGARTEN HEALTH FORMS

Please review the following information. Complete and return the necessary forms to the McFarland Primary School Health Office before the first day of school. Forms and information will also be available during annual Online Enrollment.

IMMUNIZATION FORM

WI State law requires written evidence of immunization against certain diseases, DHS Wisconsin Immunization requirements by age/grade (Stat. 252.04 (2)). If, for health, religious or personal convictions your child is not immunized, please check the appropriate waiver box (Step 4) and sign the Student Immunization Record. **The Student Immunization Record must be completed, signed by a parent/guardian, and be on file before the 30th day of school.** Students not meeting the minimum immunization requirement and have no waiver on file may be subject to exclusion. If needed, please schedule your child's appointment well in advance, as immunization clinics are often flooded with late-summer requests.

PHYSICAL EXAMINATION RECORD FORM

To be completed by your child's physician and returned to MPS Health Office (Stat. 118,25(3)). Additional health insurance resources are available here and on the MSD Health Services Website.

VISION EXAMINATION FORM (Optional)

To be completed by your child's physician, optometrist or ophthalmologist and return to MPS Health Office (Wisc. Stat. 118.135). Additional vision resources available here and on the MSD Health Services Website.

HEALTH HISTORY

Students' health history, medical conditions and medication information will be submitted during annual online enrollment. If your student will require medication to be kept at school a Medication Consent form will be required.

DENTAL RESOURCES

Information and enrollment for Bridging Brighter Smiles (BBS) preventative dental hygiene services right at school are attached. Please reach out to BBS #262-896-9891, with questions or help with enrollment. Additional dental resources available here and on the MSD Health Services Website.

QUESTIONS? PLEASE CONTACT:

Stephanie Peplinski BSN, RN, CPN, NCSN
District Nurse (EC-5th)
Email: Peplins@mcfsd.org
Office: 608-838-4679
MPS Health Office: (608) 838-4674
MPS Main Office: (608) 838-3146
MPS Fax #: (608) 838-4503

Bridging Brighter Smiles Enrollment Form – English

Bridging Brighter Smiles Formulario De Matriculación – Español

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.

Table 144.03-A
Required Immunizations for the 2021-2022 School Year and the Following School Years

Age/Grade	Required Immunizations (Number of Doses)								
5 months through 15 months	2 DTP/DTaP/DT		2 Polio			2 Hep B	2 Hib	2 PCV	
16 months through 23 months	3 DTP/DTaP/DT		2 Polio	1 MMR		2 Hep B	3 Hib	3 PCV	
2 years through 4 years	4 DTP/DTaP/DT		3 Polio	1 MMR	1 Var	3 Hep B	3 Hib	3 PCV	
Kindergarten through grade 6	4 DTP/DTaP/DT		4 Polio	2 MMR	2 Var	3 Hep B			
Grade 7 through grade 11	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			1 Mening
Grade 12	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			2 Mening

1. Requirements did not take effect until February 1, 2023, and the rule was therefore not in effect for the 2021-2022 or 2022-2023 school years. The Tdap requirement for grades 7-11 was implemented for the 2023-2024 school year. The Meningococcal (serogroup A,C,W,Y) requirement was implemented for the 2024-2025 school year.
2. Schools are not required to verify Hib and PCV vaccines for Pre-K students.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. Laboratory evidence of immunity to hepatitis B is also acceptable.
9. 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.
10. Varicella vaccine is chickenpox vaccine. Students with a reliable history of varicella disease are not required to receive the Varicella vaccine. A physician, physician assistant, or advanced practice nurse prescriber must document a reliable history of varicella disease by indicating that the student has had varicella and signing the Student Immunization Form (DHS Form 04020L). Students (excluding new enterers and kindergartners) with a parental report of disease prior to May 2024 are considered complaint.
11. One dose of Meningococcal vaccine (serogroup A,C,W,Y) is required for students entering 7th grade, and a booster dose is required for students entering 12th grade. Students are assessed for this requirement in 7th grade and 12th grade only. Current Wisconsin students in 8th-11th grade will not be assessed for this requirement until they enter 12th grade. A second dose is not required for students who received their first dose of MenACWY at age 16 years or older.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
P-44021 (08/2024)

STATE OF WISCONSIN
Wis. Stat. § 252.04

Wisconsin Immunization Requirements (English, Spanish)

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (05/2024)

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 Code)	Phone Number

Step 2 **Immunization History**

List the **month, day, and year** your child received each of the following immunizations. If you do not have an immunization record for this student, contact your doctor or public health department to obtain it. You may also use the Wisconsin Immunization Registry: https://www.dhfswir.org/PR/clientSearch.do?language=en

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					
Meningococcal (serogroup ACWY)					

Students with a reliable history of varicella disease are not required to receive the varicella vaccine. Signature from physician, physician assistant, or advanced nurse prescriber required.
☐ I attest that this student has a reliable history of varicella disease,

_____
SIGNATURE – Health Care Provider Date Signed

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 ☐ MenACWY

☐ **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 ☐ MenACWY

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 Record (English, Spanish)

Physician Examination Record

McFarland School District – Health Services

McFarland Primary School Health Office	Waubesa Intermediate School Health Office	Indian Mound Middle School Health Office	McFarland High School Health Office
Phone: 608-838-4674	Phone: 608-838-4673	Phone: 608-838-4672	Phone: 608-838-4682
Fax: 608-838-4503	Fax: 608-838-4613	Fax: 608-838-4588	Fax: 608-838-4562

This form is to be completed by your child's physician and returned or faxed to the MPS health office before the first day of school. Thank you!

STUDENT LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

This portion is to be completed by the Health Care Provider

Height:	**Weight:**
Blood Pressure/Pulse/Other Vital Signs:	
Assessment *(Cardiovascular, ENT, Gastrointestinal, Genitourinary, General Appearance, Muscular/Skeletal, Neurological, Respiratory, Skin)*:	
Physical Activity Restrictions *(nature, duration, special equipment need)*:	
Vision (Right Eye): *(Omit if completed by an optometrist or ophthalmologist)*	**Vision (Left Eye):**
Hearing (Right):	**Hearing (Left):**
Dental *(Seen by Dentist):* ❒ **Yes** ❒ **No**	**Dental Health Concerns?** ❒ **Yes** ❒ **No**
Meets current Immunization Requirements: ❒ **Yes** ❒ **No**	

Concerns/Comments *(Any health concerns which may require EMERGENCY ACTION at school, ie. seizure disorder, diabetes, cardiac condition, severe asthma, bleeding disorder, anaphylactic allergy):*

_____

_____

_____

**A Medication Order/Consent Form must be completed in order for school staff to administer medication at school.*

PHYSICIAN'S NAME & SIGNATURE _____ **DATE** _____

CLINIC NAME/ADDRESS _____ **CLINIC PHONE** _____

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.

PRESCRIPTION MEDICATION CONSENT FORM

McFarland School District Health Services

McFarland Primary School Health Office	Waubesa Intermediate School Health Office	Indian Mound Middle School Health Office	McFarland High School Health Office
Phone: 608-838-4674	Phone: 608-838-4673	Phone: 608-838-4672	Phone: 608-838-4682
Fax: 608-838-4503	Fax: 608-838-4613	Fax: 608-838-4588	Fax: 608-838-4562

Medication Order/Consent Form may be faxed to the Student's School

STUDENT INFORMATION

Student Name _____ Date of Birth _____ Grade/School _____

Indication/Diagnosis _____ Dose _____ Route _____

Medication Name _____ Strength _____ Frequency _____

Time & Condition *(if given on an as needed basis)* dose to be given _____ Start Date _____ End Date _____

PRESCRIBING PHYSICIAN/PROVIDER SIGNATURE (Required)

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect, and oversee the administration of the medication by non-medically trained designees, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in the language of the lay person.

Possible Side Effects _____ Date _____

Clinic Name/Location _____ Clinic Phone # _____

Prescribing Physician/Practitioner Name _____ Prescribing Physician/Practitioner Signature _____

❒**Yes!** This student has been instructed on the proper use of Emergency Medication (*Inhaler, Epinephrine*) and is deemed responsible to self carry their own.

Prescribing Physician/Practitioner Name _____ Prescribing Physician/Practitioner Signature _____

PARENT/GUARDIAN SIGNATURE (Required)

I give my permission to the designated school personnel to administer the above medication according to the directions provided, including on field trips. I agree to release from liability and hold the McFarland School District and its employees harmless in any and all events from the administration of this medication. I agree to notify the school, in writing, of any change in the orders. I further agree to keep the supply of the medication replenished as needed and understand only a month's supply can be stored at the school. I also give permission for the school nurse to communicate with the prescribing provider regarding this prescription. Medication must be sent in the original, LABELED MANUFACTURER OR PHARMACY CONTAINER.

Print Name _____ Preferred Phone _____

Parent/Guardian Signature _____ Date _____

Health Office Personnel Signature: _____ Date: _____