McFarland Spartans
www.mcfarland.k12.wi.us

# McFarland School District

5101 Farwell Street • McFarland, WI 53558-9216 • (608) 838-3169

District Administrator: Aaron Tarnutzer

# KINDERGARTEN HEALTH FORMS

## Please complete and return the following forms to the Conrad Elvehjem Primary School Health Office **before the first day of school**.

### IMMUNIZATION FORM

State law requires written evidence of immunization against certain diseases. If, for health, religious or personal convictions your child is not immunized, please check the appropriate waiver box 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, p*lease schedule your child's appointment well in advance*, as immunization clinics are often flooded with late-summer requests.

### HEALTH HISTORY FORM

The *Student Health History Form* should be completed and signed by you and returned to school.

### PHYSICAL EXAMINATION RECORD

The *Physical Examination Record* is to be completed by your child's physician and returned to school.

### DENTAL EXAMINATION RECORD *(Optional)*

The *Dental Examination Record* is to be completed by your child's dentist and returned to school. Information on *Bridging Brighter Smiles* is included. Additional resources available on MSD Health Services Website.

### VISION EXAMINATION FORM *(Optional)*

To be completed by a physician or optometrist and returned to school. Information on the Vision *USA* project is also attached. Additional resources available on MSD Health Services Website.

### QUESTIONS? PLEASE CONTACT:

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



McFarland School District does not discriminate on the basis of race, color, religion, national origin, ancestry, creed, pregnancy, marital status, parental status, sexual orientation, sex (including transgender status, change of sex or gender identity), English language proficiency, age, military status or physical, mental, emotional or learning disability in any of its student programs and activities.

# 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 2023-2024 School Year**

| 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 12 | 4 DTP/DTaP/DT | 1 Tdap | 4 Polio | 2 MMR | 2 Var | 3 Hep B | | |

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 6, 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. Students with a reliable history of varicella disease are not required to receive the Varicella vaccine. A parent or guardian may indicate that their student has had chickenpox on the Student Immunization Record form (F-04020L).

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 HEALTH HISTORY

## McFarland School District Health Services

5101 Farwell Street • McFarland, WI • 53558 • 608-838-4679

| STUDENT LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH |
|---|---|---|---|
| PARENT/GUARDIAN NAME | | | SCHOOL |
| PARENT/GUARDIAN HOME PHONE | PARENT/GUARDIAN MOBILE PHONE | | GRADE |

**Information obtained from this questionnaire will be kept on file in the health office and used to gain awareness of your child's health needs. Emergency or special medical concerns must be clearly communicated to school staff in order to provide safe and effective health care services.**

**1. Does your child have any of the following conditions? If yes, please explain.**

| Condition | | | |
|---|---|---|---|
| Allergies: Food, insect, medication | ☐ YES | ☐ NO | Epi-Pen? |
| Asthma: Uses inhaler? | ☐ YES | ☐ NO | |
| Attention Deficit Disorder | ☐ YES | ☐ NO | Medication/Dose: |
| Bladder or bowel problem | ☐ YES | ☐ NO | |
| Bone, muscle or joint disorder | ☐ YES | ☐ NO | |
| Congenital abnormalities | ☐ YES | ☐ NO | |
| Depression/mood disorder | ☐ YES | ☐ NO | Medication/Dose: |
| Diabetes | ☐ YES | ☐ NO | Injection or pump? |
| Ear infection/problems | ☐ YES | ☐ NO | |
| Epilepsy | ☐ YES | ☐ NO | Medication/Dose: |
| Hearing impairment | ☐ YES | ☐ NO | |
| Heart condition | ☐ YES | ☐ NO | |
| Migraines | ☐ YES | ☐ NO | |
| Speech/language disorder | ☐ YES | ☐ NO | |
| Vision impairment | ☐ YES | ☐ NO | |
| Past surgeries | ☐ YES | ☐ NO | |

**2. Will your child need any medication to be taken at school?**

**For ALL prescription medication (including Glucagon, Epi-pen, Inhaler or Diastat/Midazolam):** Please bring medication and completed ***Medication Administration Form*** (available online MSD Website-here or from the health office) – including physician's signature - to school health office.

**3. Describe any other health concerns not listed that school staff should know.**

**4. I give permission for this medical information to be shared with school staff involved in my child's care.**

PARENT/GUARDIAN SIGNATURE ____________________ DATE ____________

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# Physician Examination Record

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

| STUDENT LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH |
|---|---|---|---|
| | | | |

| | |
|---|---|
| **Height** | **Weight** |
| **Posture** | |
| **Feet** | |
| **Skin** | |
| **Abdomen** | |
| **Hernia** | **Genitals** |
| **Heart** | |
| **Blood Pressure** | **Pulse** |
| **Vision: Right eye** | **Vision: Left eye** |
| **Hearing (audiometric)** | |
| **Tonsils and adenoids** | |
| **Lungs** | |
| **Thyroid** | **Other glands** |
| **Reflexes** | |
| **Emotional status** | |
| **General condition** | |

**Classification (record Roman numeral as indicated below):** ____________

**Code I.** Unlimited activity
**Code II.** Slightly modified – Under observation
**Code III.** Definitely restricted – i.e. cardiac disease, post-acute infectious diseases, potential chests, etc.
**Code IV.** Individual Physical Education
**Code V.** Rest

**Boosters given:**

| PHYSICIAN'S SIGNATURE | DATE |
|---|---|
| | |

| CLINIC ADDRESS | CLINIC PHONE |
|---|---|
| | |

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# Dental Examination Record

**This form is to be completed by your child's dentist and returned to the CEPS health office before the first day of school. Thank you!**

STUDENT LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH

**My signature on this document signifies that this child has been seen for examination and dental concerns have been discussed with the parent/guardian.**

**Comments:**

DENTIST'S SIGNATURE | DATE

CLINIC ADDRESS | CLINIC PHONE

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BRIDGING Brighter Smiles

# Receive Dental Care Right at School!

## Get your smile back-to-school ready!

Our Preventative Dental Services Include:

- Oral Screening
- Fluoride Varnish
- Silver Diamine Fluoride
- Dental Cleaning
- Sealants
- Referral Assistance

Visits are held during the day, throughout the school year.

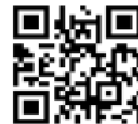
**ALL students 4k – 12th grade are encouraged to enroll!**

[enrollment.bbsmiles.org](enrollment.bbsmiles.org)

Enroll Online!

**We accept Forward Health/Badger Care!**

(We do not bill/accept other private dental insurance Funds made available through your FSA/HSA account may be utilized as form of payment, please check with your carrier for specific terms and conditions.)



For Questions Call **262-896-9891** or Visit **www.bbsmiles.org**

[Bridging Brighter Smiles Enrollment Form – English]()

[Bridging Brighter Smiles Formulario De Matriculación – Español]()

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 _____________________________________

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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.

# VISION USA – The Wisconsin Project
# Patient Application Form

VISION USA – The Wisconsin Project is an independent program run by the Wisconsin Optometric Association (WOA), a non-profit association consisting of doctors of optometry that practice in Wisconsin. The program offers comprehensive eye care services to children age 18 and under who are from low income, working families and have no insurance which covers vision and eye health care. Applications will be accepted year-round, and if approved, the applicant will be sent information in order to contact a local doctor to set up an eye exam. It is the parent/guardian's responsibility to contact the doctor and make the appointment. Each eligible child will receive a free comprehensive eye examination. **Note: WOA volunteer doctors provide these services, and a participating doctor may or may not be available in your area.**

**Eligibility requirements are as follows. Please read them carefully, to make sure your child qualifies:**

1. Patients must be age 18 or under and enrolled in K-12 school in Wisconsin.

2. Patients must have NO insurance which covers eye care (this includes vision and eye health coverage through Medicaid, Blue Cross/Blue Shield, and BadgerCare). **If the patient has insurance that covers eye care, he or she will be denied an exam through VISION USA – The Wisconsin Project.**

3. Patients must NOT have had an eye exam provided *by an eye doctor* within the last 12 months of applying for the program. **If the patient has had an eye exam by an eye doctor within the 12 months of application, he or she will be denied an exam through VISION USA – The Wisconsin Project.**

4. Family income must be within an established level according to household size; this is based upon the U.S. Federal Poverty Guidelines. ****Parents or guardians must enclose either a copy of their most recent tax return, or a verification letter from the child's school stating that the child qualifies for free/reduced lunch. If proper income verification is not included with the application, the application will be returned to the parent/guardian.**

5. Parent or guardian of the child must be currently working at least part-time.

**The applicant must meet ALL requirements to qualify for the program.**

More than one person in each family may apply for a VISION USA exam, if eligibility requirements are met. Please submit one application per child. **For more information or to obtain an application in Spanish, please visit the VISION USA page on the WOA website, www.woa-eyes.org/vision-usa-public, or call 1-877-435-2020. Please note: WOA staff does not speak Spanish.**

Send this completed form, with requested information, to the WOA office at the following address:

**VISION USA – The Wisconsin Project**
**6510 Grand Teton Plaza, Suite 312**
**Madison, WI 53719**
**Fax: 608-824-2205**

# VISION USA – The Wisconsin Project
# Patient Application Form

VISION USA - The Wisconsin Project offers comprehensive eye care services at no cost to children age 18 and under, enrolled in school, who are from low income, working families and have no insurance which covers vision and eye health care. Services are donated by volunteer optometrists and may be limited in some areas. VISION USA – The Wisconsin Project is an independent program run by the Wisconsin Optometric Association, a non-profit association consisting of doctors of optometry that practice in Wisconsin. **Eligibility requirements must be met in order to qualify.**

**You must answer ALL information and questions. Incomplete applications will be returned or discarded.** Please complete one form for each child applying. PLEASE PRINT LEGIBLY.

Child's First Name: ____________________________ Child's Last Name: _____________________________________

Parent/Guardian Name: _____________________________________________________________________________

Mailing Address: _________________________________________________________________________________

City: __________________________________________________ Zip: _______________________________________

Daytime Phone Number: (_______) ___________________________

Child's Date of Birth: _____________ Child's Social Security Number (***required for U.S. citizens**): _________________

Child's Gender (circle one): Male Female Date child will/did enter kindergarten: _______________________

**Please Answer All Questions Below (circle either "yes" or "no" for each question):**

1. Is the applicant age 18 or under? (**required for approval**) YES NO
2. *Is the applicant a U.S. citizen? (**not required for approval**) YES NO
3. Does applicant have eye care coverage by any type of government or private health care insurance (ex. Medicaid, Medicare, Blue Cross/Blue Shield, BadgerCare)? (**If yes, applicant will be denied an exam through VISION USA – The Wisconsin Project**). YES NO
4. Has applicant had an eye examination at an *eye doctor's* office within the last 12 months? (**If yes, applicant will be denied an exam through VISION USA – The Wisconsin Project**). YES NO
5. What is the total number of people living in your household, including applicant? (**response required**) _____________
6. What was your household's adjusted gross income last year? (**response required**) ** ________________________**
7. Is a parent or guardian of the above child currently working at least part-time? (**response required**) YES NO
8. Who referred you to this program? __________________________________

****Please include a copy of your most recent federal tax return or school verification of the child's free/reduced lunch. This application will be returned, if income verification is not included. If it is discovered that applicant is ineligible for the program after the exam has taken place, the cost incurred will be the responsibility of the parent/guardian of that child.**

Your completed application form will be reviewed to determine your child's eligibility. If he or she qualifies for the program, you will receive a letter with information in order to contact a participating doctor in your area. If your child does not qualify, you will be notified in writing within two to four weeks of receipt of your application. **Please return the completed application to: VISION USA – The Wisconsin Project, 6510 Grand Teton Plaza, Suite 312, Madison, WI 53719.**