

# WINNECONNE COMMUNITY SCHOOL DISTRICT



Learning Today...  
Leading Tomorrow

Dear 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 in our school district. Please take some time to review the information. Understand this information is separate from the online registration.

**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 5 <sup>th</sup> grade	4 DTP/DTaP/DT/Td	4 Polio	3 Hep B	2 MMR	2 Var	
Grades 6 <sup>th</sup> through 12 <sup>th</sup>	4 DTP/DTaP/DT/Td	1 Tdap	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](mailto:krausej@w-csd.org).

Sincerely,

Mrs. Krause, BSN, RN  
District School Nurse

**Home of the 2013-2014 Football and Spirit Team State Champions!**

233 S. 3rd Ave. | PO Box 5000 | Winneconne, WI 54986 | [www.winneconne.k12.wi.us](http://www.winneconne.k12.wi.us)

Administration 920.582.5802 | High School 920.582.5810 | Middle School 920.582.5800 | Elementary School 920.582.5803

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
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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 _____
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TB Skin Test (Recommended for children in high risk groups) Date Read _____ Result _____ mm	Height _____	Weight _____
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	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
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\*\*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
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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
- 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

**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
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**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
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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