EDGERTON SCHOOL DISTRICT

LEARN TODAY. LEAD TOMORROW.

INSTRUCTIONS FOR HEALTH FORMS

- When your child is examined please have both the doctor and the dentist complete correct sections of the form. These forms should be returned to your student's school health office as soon as possible. (Your student's medical and dental providers' forms are also acceptable)

- Preventative Vision and Hearing Screenings are completed in the Fall for all 4K, 5K, 1st, 3rd and 8th graders and any new to the district students. Screenings may also be completed upon request of a parent/guardian.

- A child should not be in school if they do not feel well or if there is some suspicion of a communicable disease.

- Unless exempted for health, religious, or personal conviction reasons every child to been rolled in the Edgerton School District is required by Wisconsin State Checkpoint Law to have completed or be in the process of completing the following immunizations:

ECH & 4 Year K	5K – Grade 12
4 DTP/DTaP/DT	**5 DTP/DTaP/DT**
3 Polio	**4 Polio**
1 MMR	**2 MMR**
(Measles, Mumps, Rubella)	
1 Varicella Vaccine	**2 Varicella Vaccine**
(Chickenpox - Or the year that your child had the disease)	
3 Hepatitis B	**3 Hepatitis B**

Julie Lodahl	Deb Hogue	Barb Kronforst	Tracie Kransberger	Brenda Lein
Primary Heath Office	Intermediate Health Office	YVES Health Office	EMS Health Office	EHS Health Office
608-561-6010x11163	608-561-6010x11162	608-884-4931	608-561-6221	608-561-6025

Sandy Biviano, RN, BSN
Edgerton School District Nurse
608-561-6061

Physical and Dental Form

TO BE FILLED OUT BY PARENT/GUARDIAN

Child's Name: _____Birthdate:_____Sex ____ School:_____ Grade:___

Parent/ Guardian:_____Address:_____Phone:_____

Parent/ Guardian:_____Address:_____Phone:_____

Primary Physician:_____ Date of last visit: _____

Clinic Name: _____Clinic Address:_____Phone:_____

Dentist's Name:_____ Date of last visit: _____

Dental Office: _____Address: _____ Phone:_____

Was dental treatment completed? Yes_____ No_____ Not needed_____

In an effort to provide a safe, healthy environment for your child at school, we would like to know about your child's health needs.

1. Have there been any major changes in the family situation in the last year, such as a family moving, loss of someone close, or a serious illness of either parent? Yes ____ No ____ If yes, please describe:

2. Has your child had any serious accidents, illnesses, hospitalizations or injuries in the past year? Yes ____ No ____ If yes, please describe:

3. Please describe any health concerns or medical diagnosis your child may have (i.e. asthma, seizure disorder, diabetes, hearing or vision concerns, or <u>any</u> health concern).

4. Does your child take any medications regularly? Yes ____ No ____ If yes, please list.

5. Please give any additional comments/information that you would like to share about your child.

6. Has there been any tuberculosis exposure? Yes ____ (yr _____) No ____. If yes, please describe treatment.

7. May this information be shared with appropriate school personnel, as determined by the school nurse?
Yes _____ No _____

8. If your child has a health concern, may this information be included on a health concern list that is distributed to staff and maintained in the school health office? Yes ____ No ____

Signature of Parent or Guardian: _____Date:_____

PLEASE RETURN TO YOUR CHILD'S SCHOOL HEALTH OFFICE

(OVER)

TO BE FILLED OUT BY YOUR PRIMARY PHYSICIAN

Physical Examination

Height _____ Weight _____ Blood Pressure _____ Pulse _____
General appearance _____ General nutrition _____
Vision: Acuity _____ Right eye _____ Left eye _____
Hearing: Audiogram Right ear _____ Left ear _____

TEST	NORMAL	ABNORMAL	NOT DONE	COMMENTS
Skin				
Head				
Eyes				
Ears				
Nose				
Mouth				
Throat				
Neck				
Nodes				
Chest				
Lungs				
Heart				
Abdomen				
Genitourinary				
Neuromuscular				
Spine				
Extremities				
Anus				
Sexual Development				

Please describe any significant disabilities, developmental concerns or abnormal findings which would be helpful for the nurse to know about when providing care in the schools.

Please list any immunizations given today:

Is this child on any routine or long term medication? Yes ____ No ____ If yes, please describe:

Physician's Signature: _____ Date: _____Phone: _____

TO BE FILLED OUT BY THE DENTIST

Dental Examination:

__Child is involved in a preventive dental health program. __ All necessary dental work has been completed.
__Treatment is in progress. __ No dental work is necessary.
Dentist's Signature: _____ Date: _____ Phone:_____

(OVER)

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.