SCHOOL DISTRICT OF ONALASKA
School Health Program – Medical Examination

Student's Name: _____ Date of Birth: _____ M____ F____
Parent/Guardian: _____ Phone: _____
HEALTHCARE PROVIDER MUST COMPLETE THE FOLLOWING:
Are there problems with any of the following? If yes, describe with recommendations for school personnel:

	Yes	No	
Allergies			
Asthma			
Headaches/Migraines			
Seizures			
Diabetes			
Operations/Serious Injury			
Growth and Development			
Skin			
Bones/Joints/Spine			
Neuromuscular			
Gastrointestinal			
Any defect of: ( )Speech ( ) Vision ( ) Hearing			
Is this student subject to limited conditions in: ( )Classroom Activity ( ) Physical Education			
Is child taking medication that would be given during school hours? If yes, name medication and reason.			

Tuberculin Test: _____ _____
Date Results

Health Care Provider Comments:

Provider's Signature_____ Date_____

Affiliated Clinic:_____Gundersen/Lutheran _____Mayo _____Other

PARENT MUST COMPLETE
Information provided on this medical examination may be included in the Health Alert that is used to inform staff of student health problems. If indicated, the information will be secured on a computer software program and a printed copy will be kept in the school health office. I give permission for information to be released to school personnel: building principal, teacher(s), building health aide, building secretaries, paraprofessional, district nurses, other employees, bus drivers and volunteers who may be working with or supervising my child. The teacher may include a printed list of my child's health information in the Substitute Teacher's folder at their discretion.

Authorization: this authorization is valid for one calendar year. I understand that I may revoke this authorization at any time by submitting written notice to the Pupil Services Department in the School District of Onalaska. I recognize that the health information listed may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by the Wisconsin Statues 118.25 (2m((a)(b) and 146.82-146.83. I also understand that is I refuse to sign, such refusal will not interfere with my child's ability to obtain health services in the School District of Onalaska.

Parent/Guardian Signature_____Date_____

SCHOOL DISTRICT OF ONALASKA

SCHOOL HEALTH PROGRAM

Kindergarten Dental Examination

Student's Name:_____ Date of Birth:_____

To the Parents: Kindergarten pupils enrolling in school for the first time are required by Board of Education Policy to submit a record of examination by a dentist. Thank you for helping to ensure your child's health and meeting this requirement by having your dentist complete this form.

To the Dentist: Check one of the following statements:

( ) 1. No dental work is necessary

( ) 2. Routine dental care has been completed.

( ) 3. Dental work in process:_____

Signature of Dentist:_____ Date:_____

Phone:_____

Please return this form to the school office on or prior to the first day of school.

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.