# VERONA AREA SCHOOL DISTRICT

Medical Evaluation

To the Health Care Provider: Please complete and sign.

______________________ ____/__ ___ has had a complete history and physical exam on ____________.
Student's Name Birth Date Month/Day/Year

**Screenings:** (Note) these are recommended under Wisconsin State Law.

**Vision Screen** Right Left
With Glasses 20/ 20/
Without Glasses 20/ 20/
□ Referral made

**Auditory Screen** Type:______________________________
Right: Pass □ Fail □
Left: Pass □ Fail □
□ Referral Made

**IMMUNIZATIONS:** (Note) these are required under Wisconsin State Law.

□ Wisconsin Immunization Registry Record Attached

| | Dose 1 | Dose 2 | Dose 3 | Dose 4 | Dose 5 | Dose 6 |
|---|---|---|---|---|---|---|
| DTP/DTaP | * | * | * | * | * | |
| IPV/OPV | * | * | * | * | | |
| HEP B | * | * | * | | | |
| MMR | * | * | | Had disease: (date) | | |
| VARICELLA | * | * | | Had disease: (date) | | |
| | | | | | | |

* = required immunizations

**EXEMPTION**

□ Personal Waiver □Medical Waiver □ Religious Waiver

Parent/Guardian Signature ________________________________Date________________

Physician Signature for Medical Waiver ______________________________ Date_______

This student has the following problems which may adversely affect his/her educational experience:

□ Vision □ Auditory □ Speech/Language □ Physical □ Emotional/Social □ Behavior

□ This student has a health condition which may require emergency action at school, e.g. seizure, allergies. Specify below. Attach additional sheets if necessary.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

□ This student is on medication. (Prescription medications require a Doctor's Signature- see back of this form)

□ This student may participate fully in the school program, including physical education activities.

□ This student may participate in the school program and physical education with the following restrictions/adaptations:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

□ I would like to discuss information in this report with the school nurse.

______________________________ ______________________________ ______________
Signature of Health Care Provider Name (please print or type) Date