

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	Auditory Screen	Type:
With Glasses	20/	20/	Right: Pass ☐	Fail ☐
Without Glasses	20/	20/	Left: Pass ☐	Fail ☐
☐ Referral made			☐ 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.
☐ 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