



STOUGHTON AREA SCHOOL DISTRICT

District Office

320 North Street • Stoughton, WI 53589-1733
(608) 877-5000

WWW.STOUGHTON.K12.WI.US

KINDERGARTEN HEALTH FORMS

Please review the following information. Complete and return the necessary forms to your **Stoughton Area School District Elementary School Health Office** before the first day of school. Forms and information will also be available during annual Online Enrollment.

IMMUNIZATION FORM WI State law requires written evidence of immunization against certain diseases, [DHS Wisconsin Immunization requirements](#) by age/grade (Stat. 252.04 (2)). If, for health, religious or personal convictions your child is not immunized, please check the appropriate waiver box (Step 4) and sign the Student Immunization Record. [The Student Immunization Record](#) must be completed, signed by a parent/guardian, and be on file before the 30th day of school. Students not meeting the minimum immunization requirement and have no waiver on file may be subject to exclusion. If needed, please schedule your child's appointment well in advance, as immunization clinics are often flooded with late-summer requests.

PHYSICAL EXAMINATION RECORD FORM To be completed by your child's physician and returned to the School Health Office (Stat. 118.25(3)).

VISION EXAMINATION FORM (Optional) [To be completed by your child's physician, optometrist or ophthalmologist](#) and returned to the school Health Office (Wisc. Stat. 118.135). Additional vision resources are available if needed, please contact the District Nurse for information.

HEALTH HISTORY Students' health history, medical conditions and medication information will be submitted during annual online enrollment. If your student will require medication to be kept at school, a [Medication Consent](#) form will be required before medication can be administered.

DENTAL RESOURCES Information and enrollment for **Bridging Brighter Smiles (BBS)** preventative dental hygiene services right at school are attached. Please reach out to BBS at 262-896-9891 with questions or for help with enrollment.



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STOUGHTON AREA SCHOOL DISTRICT HEALTH OFFICES

The Stoughton Area School District Health Services team works together to promote the health and safety of all students. Each building is staffed with health office personnel trained to assist with medical needs, immunization compliance, and emergency care. Please use the contact information below to connect with your student's specific school health office.

Fox Prairie Elementary Health Office Phone: 608-877-5104 | Fax: 608-877-5184

Sandhill Elementary Health Office Phone: 608-877-5404 | Fax: 608-877-5408

Kegonsa Elementary Health Office Phone: 608-877-5204 | Fax: 608-877-5278

River Bluff Middle School Health Office Phone: 608-877-5504 | Fax: 608-877-5508

Stoughton High School Health Office Phone: 608-877-5664 | Fax: 608-877-5619

SASD Nurse Office Phone: 608-877-5405 | Fax: 608-877-5408



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KINDERGARTEN PHYSICIAN EXAMINATION RECORD *This form is to be completed by your child's physician and returned or faxed to the school health office before the first day of school. Thank you!*

STUDENT INFORMATION (To be completed by the Health Care Provider)

Last Name:	Date Of Birth:
First Name:	Height:
Middle Initial:	Weight:

VITAL SIGNS	RESULTS	SCREENING	RESULTS
Blood Pressure		Vision Right	
Pulse		Vision Left	
Dental (Seen by Dentist)	☐ Yes ☐ No	Hearing Right	
Dental Concerns?	☐ Yes ☐ No	Hearing Left	
Immunizations	<i>Meets requirements?</i>	☐ Yes	☐ No

CONCERNS / EMERGENCY ACTION ITEMS

(Please provide details for Seizures, Diabetes, Cardiac, Asthma, or severe Allergy)



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HEALTH CLEARANCE & REQUIREMENTS

System Assessment

(Cardiovascular, ENT, GI, GU, Appearance, Muscular, Neuro, Respiratory, Skin):

Physical Activity Restrictions:

Provider Signature: _____ **Date:** _____

Clinic Name/Stamp: _____

Address: _____

Phone: _____ **Fax:** _____

Non-Discrimination Statement: The Stoughton Area School District does not discriminate on the basis of race, color, religion, national origin, ancestry, creed, pregnancy, marital status, parental status, sexual orientation, sex, including transgender status, change of sex or gender identity, English language proficiency, age, military status, or physical, mental, emotional, or learning disability in any of its student programs and activities.

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 _____

STUDENT IMMUNIZATION LAW AGE/GRADE REQUIREMENTS

The following are the minimum required immunizations for each age and grade level according to the Wisconsin Student Immunization Law. These requirements can be waived for health, religious, or personal conviction reasons. Additional immunizations may be recommended for your child depending on his or her age. Please contact your doctor or local health department to determine if your child needs additional immunizations.

**Table 144.03-A
Required Immunizations for the 2021-2022 School Year and the Following School Years**

Age/Grade	Required Immunizations (Number of Doses)								
5 months through 15 months	2 DTP/DTaP/DT		2 Polio			2 Hep B	2 Hib	2 PCV	
16 months through 23 months	3 DTP/DTaP/DT		2 Polio	1 MMR		2 Hep B	3 Hib	3 PCV	
2 years through 4 years	4 DTP/DTaP/DT		3 Polio	1 MMR	1 Var	3 Hep B	3 Hib	3 PCV	
Kindergarten through grade 6	4 DTP/DTaP/DT		4 Polio	2 MMR	2 Var	3 Hep B			
Grade 7 through grade 11	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			1 Mening
Grade 12	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			2 Mening

- Children 5 years of age or older who are enrolled in a Pre-K class should be assessed using the immunization requirements for Kindergarten through Grade 5, which would normally correspond to the individual's age.
- D = diphtheria, T = tetanus, P = pertussis vaccine. DTaP/DTP/DT/Td vaccine for all students Pre-K through 12: Four doses are required. However, if a student received the 3rd dose after the 4th birthday, further doses are not required. **Note:** A dose four days or less before the 4th birthday is also acceptable.
- DTaP/DTP/DT vaccine for children entering Kindergarten: Each student must have received one dose after the 4th birthday (either the 3rd, 4th, or 5th dose) to be compliant. **Note:** a dose four days or less before the 4th birthday is also acceptable.
- Tdap is an adolescent tetanus, diphtheria, and acellular pertussis combination vaccine. If a student received a dose of a tetanus containing vaccine, such as Td, within five years before entering the grade in which Tdap is required, the student is compliant and a dose of Tdap vaccine is not required.
- Polio vaccine for students entering grades Kindergarten through 12: Four doses are required. However, if a student received the 3rd dose after the 4th birthday, further doses are not required. **Note:** a dose four days or less before the 4th birthday is also acceptable.
- Laboratory evidence of immunity to hepatitis B is also acceptable.
- MMR is measles, mumps, and rubella vaccine. The first dose of MMR vaccine must have been received on or after the 1st birthday. Laboratory evidence of immunity to all three diseases (measles and mumps and rubella) is also acceptable. **Note:** A dose four days or less before the 1st birthday is also acceptable.
- Varicella vaccine is chickenpox vaccine. Students with a reliable history of varicella disease are not required to receive the Varicella vaccine. A physician, physician assistant, or advanced practice nurse prescriber must document a reliable history of varicella disease by indicating that the student has had varicella and signing the Student Immunization Form (DHS Form 04020L). Current Wisconsin students with a parental report of varicella prior to February 1, 2023 are not required to receive Varicella vaccine.
- One dose of Meningococcal vaccine (serogroup A,C,W,Y) is required for students entering 7th grade, and a booster dose is required for students entering 12th grade. Students are assessed for this requirement in 7th grade and 12th grade only. Current Wisconsin students in 8th-11th grade will not be assessed for this requirement until they enter 12th grade. A second dose is not

required for students who received their first dose of MenACWY at age 16 years or older.

DEPARTMENT OF HEALTH SERVICES Division of Public
Health

P-44021 (05/2024)



STATE OF WISCONSIN [Wis. Stat. § 252.04](#)

STUDENT IMMUNIZATION RECORD

Instructions to Parent: Complete and return to school within **30 days after admission**. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

Step 1

Personal Data

Please Print

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year
Name of Parent/Guardian/Legal Custodian		Address (Street, City, State, ZIP Code)		Phone Number	

Step 2

Immunization History

List the **month, day, and year** your child received each of the following immunizations. If you do not have an immunization record for this student, contact your doctor or public health department to obtain it. You may also use the Wisconsin Immunization Registry:
<https://www.dhfs.wisconsin.gov/immunization/registry/>

Type of Vaccine*	First Dose MM/DD/YYYY	Second Dose MM/DD/YYYY	Third Dose MM/DD/YYYY	Fourth Dose MM/DD/YYYY	Fifth Dose MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine					
Meningococcal (serogroup ACWY)					

Students with a reliable history of varicella disease are not required to receive the varicella vaccine. Signature from physician, physician assistant, or advanced nurse prescriber required.

☐ I attest that this student has a reliable history of varicella disease,

SIGNATURE – Health Care Provider Date Signed

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? Check all that apply.

☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B

If **yes**, provide laboratory report(s)

Step 3

Requirements

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

Step 4

Compliance Data

Student Meets All Requirements

Sign at Step 5 and return this form to school.

Or

Student Does Not Meet All Requirements

Check the appropriate box below, sign at Step 5, and return this form to school. **Please note that incompletely immunized students may be excluded from school if an outbreak of one of these diseases occurs.**

☐ Although my child has **not** received **all** the required doses of vaccine, the **first dose(s)** has/have been received. I understand that the **second dose(s)** must be received by the 90th school day after admission to school this year, and that the **third dose(s)** and **fourth dose(s)** if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

Note: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

Waivers (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ For health reasons this student should not receive the following immunizations

SIGNATURE – Physician Date Signed

☐ For religious reasons, I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella ☐ MenACWY

☐ For personal conviction reasons, I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella ☐ MenACWY

Step 5

Signature

This form is complete and accurate to the best of my knowledge. Check one: (I do ☐ I do not ☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student

Date Signed



HEALTHY SMILES, MADE EASY!

Our dental hygiene team visits your school to provide preventative dental care to students -right at school, during the school day.

NO COST FOR SERVICES

Forward
Health
(BadgerCare)
Accepted

**Our services are growing.
We're now able to offer even more!**

- X-Rays
- Silver Diamine Fluoride
- Sealant Retention Check
- Teeth Cleaning
- Oral Screening
- Teledentistry
- Oral Health Education
- Fluoride Varnish
- Referral Assistance
- Dental Sealants

SCAN HERE



OR

**VISIT OUR
WEBSITE AT:**

[Bridgingbrightersmiles.org/forms](https://bridgingbrightersmiles.org/forms)

For questions please call  262-896-9891

Bridging Brighter Smiles Enrollment Form – [English](#)

Bridging Brighter Smiles Formulario De Matriculación – [Español](#)