Fontana Jt. 8 School District
Home of the Falcons

450 South Main Street
Fontana, WI 53125
Ph. 262.275.6881
Fax 262.275.5360
www.fontana.k12.wi.us

Welcome to Fontana Jt. 8 School District. We are so glad that you are joining the Falcon family. Please review the following information regarding required registration forms.

Student Registration Packets are for the following students:
-Students entering 4K/5K (required even if attended Falcons Early Childhood Learning Center)
-Students entering 6th grade
-Any student that is new to Fontana, or transferring from another district in/out-of-state.

Please complete and return the following forms to the School Health Office before the first day of school.

1. **IMMUNIZATION FORM**

State law requires written evidence of immunization against certain diseases. If, for health, religious or personal convictions your child is not immunized, please check the appropriate waiver box 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.https://www.dhs.wisconsin.gov/immunization/reqs.htm
https://www.dhs.wisconsin.gov/immunization/wir.htm

2. **HEALTH HISTORY FORM**

The Student Health History Form should be completed and signed by you and returned to school.

3. **PHYSICAL EXAMINATION RECORD**

The Physical Examination Record is to be completed by your child's physician and returned to school.

4. **DENTAL EXAMINATION RECORD**

The Dental Examination Record is to be completed by your child's dentist and returned to school. Information on Bridging Brighter Smiles is included.

5. **VISION EXAMINATION FORM**

To be completed by physician or optometrist and returned to school.

QUESTIONS? Please contact the school health office:
Julie Lohse, MSN, BSN, RN
Health Services Coordinator/District Nurse
Email: jlohse@fontana.k12.wi.us

Office: 262-275-6881 extension:

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.

Grade/Age	Number of Doses					
Pre-K (ages 2 through 4 yrs)[1]	4 DTaP/DTP/DT[2]		3 Polio	3 Hepatitis B[6]	1 MMR[7]	1 Varicella[8]
Kindergarten through Grade 5	4 DTaP/DTP/DT/Td[2,3]		4 Polio[5]	3 Hepatitis B[6]	2 MMR[7]	2 Varicella[8]
Grades 6 through 12	4 DTaP/DTP/DT/Td[2]	1 Tdap[4]	4 Polio[5]	3 Hepatitis B[6]	2 MMR[7]	2 Varicella[8]

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. Laboratory evidence of immunity to hepatitis B is also acceptable.
7. 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.
8. Varicella vaccine is chickenpox vaccine. A history of chickenpox disease or laboratory evidence of immunity to varicella is also acceptable.

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.

Grade/Age	Number of Doses					
Pre-K (ages 2 through 4 yrs)[1]	4 DTaP/DTP/DT[2]		3 Polio	3 Hepatitis B[6]	1 MMR[7]	1 Varicella[8]
Kindergarten through Grade 5	4 DTaP/DTP/DT/Td[2,3]		4 Polio[5]	3 Hepatitis B[6]	2 MMR[7]	2 Varicella[8]
Grades 6 through 12	4 DTaP/DTP/DT/Td[2]	1 Tdap[4]	4 Polio[5]	3 Hepatitis B[6]	2 MMR[7]	2 Varicella[8]

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. Laboratory evidence of immunity to hepatitis B is also acceptable.
7. 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.
8. Varicella vaccine is chickenpox vaccine. A history of chickenpox disease or laboratory evidence of immunity to varicella is also acceptable.

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.

Fontana Jt. 8 School District
Home of the Falcons

450 South Main Street
Fontana, WI 53125
Ph. 262.275.6881
Fax 262.275.5360
www.fontana.k12.wi.us

STUDENT HEALTH HISTORY (Completed for new enrollment/yearly at registration)

Information obtained from this questionnaire will be kept on file in the health office and used to gain awareness of your child's health needs. Emergency or special medical concerns must be clearly communicated to school staff in order to provide safe and effective health care services.

Does your child have any of the following conditions? If yes, please explain.

Condition	Yes	No	Detailed Explanation if selected Yes
Allergies (Food, Insect, Medication)			***EpiPen use?***
Asthma			***Inhaler use?***
Attention Deficit Disorders			***Medication Use?***
Bladder or bowel problem			
Bone, muscle or joint disorder			
Congenital Defects			
Depression/Anxiety			***Medication Use?***
Diabetes			
Ear infections/Hearing Impairment			
Heart Conditions			
Migraines			
Speech Language Disorder			
Visual Impairment			***Glasses worn?***
Past Surgeries?			

Concussion History			
Other Concerns			

2. Will your child need any medication to be taken at school?

_____

For ALL prescription medication (including Glucagon, Epi-pen, inhaler or Diastat/Midazolam): Please bring medication and completed Medication Administration Form (available online or from the health office) – including physician's signature - to school health office. Please contact the School Nurse to discuss any specific concerns.

4. I give permission for this medical information to be shared with school staff involved in my child's care.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Fontana Jt. 8 School District
Home of the Falcons

450 South Main Street
Fontana, WI 53125
Ph. 262.275.6881
Fax 262.275.5360
www.fontana.k12.wi.us

Student Physical Examination Report

(Must be completed by a Physician/Medical Provider)

Student Name:_____Gender:_____Grade:_____D.O.B.___/___/_____

Height_____Weight_____Blood Pressure_____/_____

Please indicate if the student has any of the following medical conditions, or concerns with an area in the chart below:

	No concerns	Detailed Concerns or Comments
Asthma/Respiratory Disorders/Lungs		
Diabetes		
Seizure/Neurological or Nervous System Disorders		
Eyes		
Ears		
Nose		
Throat		
Skin		
Heart/Cardiovascular		
GI/Abdomen		
Orthopedic, Skeletal Structure		
Nutrition		
Auto-Immune Concerns		
Other:		

Physician or Medical Provider Comments: _____

:_____

_____

Does the student have any allergies? Please indicate which allergies are a concern below

Source of Allergy	Type of reaction
Food	
Stinging Insects	
Medicine	
Environmental	
Other	

Does the student require an EpiPen, Auvi-Q, or any other type of emergency injectable to be present at school? Yes or No

Does the student require an over the counter antihistamine medication to be administered at school? Yes or No

Have arrangements been made for further medical attention?

Should this student have

	YES	NO
Have arrangements been made for further medical attention?		
Is the pupil capable of carrying a full program of school work?		
Should this student have any restrictions on physical education, athletics, or other activities? Please explain below if yes is marked.		

_____ _____

Provider Signature Date

_____

Provider Address

(___)_____ __(_____)_____

Provider Phone Number Provider Fax Number