BURLINGTON
AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
Jill Dreger BSN, RN, Director of Health Services
Lori Sanchez BSN, RN
209 Wainwright Avenue, Burlington, WI 53105
(262) 763-0210 FAX (262) 763-0215

"Optimal health and wellness is essential for proper development and learning."

Dear Parent / Guardian:

The health services department consists of two Registered Nurses and seven Health Aides. Both RNs have long-term experience in school nursing and provide the training, education and direction for the health aides, who assist in the care of your child(ren). The health aides are NOT registered or licensed nurses. They are trained and certified in CPR/First Aid, medication administration and have experience in dealing with the health concerns of school age children. When children are too ill to remain in school, the parent/guardian will be notified. Therefore, it is important to provide the school with alternative emergency contacts in the event parent/guardian is unavailable. If urgent medical attention is necessary EMS may be called. **Please remember to keep all emergency information current and up to date.**

Health Information:

1. Immunizations are necessary for school attendance. For information on required vaccines listed by age/grade, please refer to the Immunization Requirements page. It is your responsibility to provide these dates to the health office of your child's school. **Please submit immunization records by the first day of school.** This information can be obtained through your physician or may be found on the Wisconsin Immunization Registry (WIR).

2. 4K & 9th Grade:
   A complete **physical exam, dental exam and vision exam** are recommended before entering 4K and 9th grade - you will find these forms attached to this packet. This should be done as early as possible so all necessary care can be completed before school starts. Return these completed forms to your child's school health office.

3. The School Medication Policy and consent forms are available on the Burlington Area School District website on the Health Services page. In the event your child would need to take medication at school please review this policy. Medication consent forms may also be picked up in any school health office. All medications are to be brought to school and picked up from school by parent/guardian. Medications should be given at home whenever possible, however, if medication is necessary at school, it may be given with proper paperwork and following BASD medication procedures.

Please contact us at any time with changes or updates to your child's health. We look forward to working with you and wish you and your child a healthy school year!

Jill Dreger BSN, RN
Director of Health Services

Lori Sanchez BSN, RN
School Nurse

BURLINGTON
AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
Jill Dreger BSN, RN, Director of Health Services
Lori Sanchez BSN, RN
209 Wainwright Avenue, Burlington, WI 53105
(262) 763-0210 FAX (262) 763-0215

"Optimal health and wellness is essential for proper development and learning."

Student Health Condition & Current Medications

Student Name: _____Birthdate: _____/_____/_____ School: _____

Grade: _____ Parent / Guardian Name: _____Phone #: _____

* **If NO HEALTH CONDITIONS** - please check here _____, then sign & date the bottom of this page.

Health Conditions: (Check all that apply & return this ***COMPLETED*** form for the Health Office at your child's school.)

Yes	No	Any condition requiring medication - be sure to list that below
_____	_____	Asthma: _____
_____	_____	Diabetes (pick up MD plan at health office to be completed by your physician): _____
_____	_____	Heart Problems: _____
_____	_____	Cancer: _____
_____	_____	Arthritis - Rheumatoid / Fibromyalgia: _____
_____	_____	Bleeding Disorder: _____
_____	_____	Seizure Disorder: _____
_____	_____	Migraines - Headache / Abdominal: _____
_____	_____	Scoliosis: _____
_____	_____	Vision Impairment - Glasses / Contacts / Blind: _____ Right Eye _____ Left Eye
_____	_____	Hearing Impairment - Hearing Aid: _____ Right Ear _____Left Ear
_____	_____	ADHD / ADD: _____
_____	_____	Depression / Anxiety: _____
_____	_____	Allergies (Be specific in severity, type and reactions seen): _____
_____	_____	Food: _____
_____	_____	Insect: _____
_____	_____	Medication: _____
_____	_____	Environmental: _____
_____	_____	Other Health Problems (specify) _____

Medications: (List ALL medications that your child is currently taking & the reason)

	Medication Name	Dose	Time & Place	Purpose
1.			_____ ☐home ☐school	
2.			_____ ☐home ☐school	
3.			_____ ☐home ☐school	
4.			_____ ☐home ☐school	

I hereby authorize the school nurse or designee to give 1st Aid / Treatment to this child when necessary and if I am unable to be reached in an emergency, to call my Family Physician and/or EMS and to share this health information with the individuals who have a need to know.

_____ _____/_____/_____

Signature of Parent /Guardian REQUIRED Date

BURLINGTON
AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
Jill Dreger BSN, RN, Director of Health Services
Lori Sanchez BSN, RN
209 Wainwright Avenue, Burlington, WI 53105
(262) 763-0210 FAX (262) 763-0215

"Optimal health and wellness is essential for proper development and learning."

Dental Health

(Recommended for K & 9th Grade)

Last Name: _____ First Name: _____ MI: _____

School: _____ Grade: _____ DOB: _____

Parent / Guardian: _____

Address: _____

To The Parent / Guardian:
The Burlington Area School District has a health program that is designed to improve, protect and promote the health of each child. As part of this health program we strongly urge you to take your child to the dentist of your choice at least twice a year for a dental examination and whatever treatment may be necessary. When the examination and treatment are completed, this form should be returned to the school.

To the Dentist:
Check one of the following statement before signing this form:

1. Teeth were found in satisfactory condition ☐
2. All necessary dental work has been completed ☐
3. Dental work is necessary and in the process of being completed ☐

Signature of Dentist: _____ Date: _____

Address: _____ Phone: _____

BURLINGTON
AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
Jill Dreger BSN, RN, Director of Health Services
Lori Sanchez BSN, RN
209 Wainwright Avenue, Burlington, WI 53105
(262) 763-0210 FAX (262) 763-0215

"Optimal health and wellness is essential for proper development and learning."

Physical Examination

(Recommended for K & 9th Grade)

Student's Name: _____ **Birthdate:** _____

Address: _____**School**: _____ Grade: _____

Parent / Guardian Name: _____**Phone:** _____

	Normal	Abnormal	Referral	Not Evaluated	
General Appearance	( )	( )	( )	( )	
Posture, Gait	( )	( )	( )	( )	
Speech	( )	( )	( )	( )	
Head	( )	( )	( )	( )	Ht: _____
Skin	( )	( )	( )	( )	
Eyes, External Aspects	( )	( )	( )	( )	Wt: _____
Ears, External Aspects	( )	( )	( )	( )	
Ears, Internal Aspects	( )	( )	( )	( )	B/P: _____
Nose, Mouth, Pharynx	( )	( )	( )	( )	
Teeth	( )	( )	( )	( )	Pulse: _____
Heart	( )	( )	( )	( )	
Lungs	( )	( )	( )	( )	Resp: _____
Abdomen (include hernia)	( )	( )	( )	( )	
Bones, Joints, Muscles	( )	( )	( )	( )	
Neurological / Social	( )	( )	( )	( )	
Gross Motor	( )	( )	( )	( )	
Fine Motor	( )	( )	( )	( )	
Glands (lymphatic/thyroid)	( )	( )	( )	( )	
Muscular Coordination	( )	( )	( )	( )	

Allergies (Be Specific): _____ **Current Medications**: _____
_____ _____
_____ _____

Acute / Chronic Conditions: (Diabetes / Asthma / Etc.) _____

Immunizations Given Today: ( )DTP ( )Polio ( )Hib ( )MMR ( )Varicella 1 - 2 ( )HBV 1 - 2 – 3
( )Other _____ ( ) Up-to-date (please attach record)

Restrictions / Recommendations: _____

Physician Signature: _____ **Date**: _____

Physician Address: _____**Phone No**: _____

BURLINGTON AREA SCHOOL DISTRICT

HEALTH SERVICES DEPARTMENT
Jill Dreger BSN, RN, Director of Health Services
Lori Sanchez BSN, RN
209 Wainwright Avenue, Burlington, WI 53105
(262) 763-0210 FAX (262) 763-0215

"Optimal health and wellness is essential for proper development and learning."

STUDENT VISION & EYE HEALTH EXAMINATION FORM

(Recommended for K & 9th Grade)

Because 80% of all learning in children is obtained through vision, it is vital that your child receive the proper vision and eye health care. As many as 25% of all children, have vision problems significant enough to prevent them from succeeding in school. Moreover, most children do not know they have a vision problem. As adults, we must act on their behalf. The State of Wisconsin encourages parents of incoming students to have a vision exam and that your optometrist fills out the following information. This form is to be completed and returned to school.

Student's Name: _____ Birth Date: _____ Sex: _____

Parent / Guardian: _____ Phone: _____

TO EYE CARE PROFESSIONAL: Please complete the following information.

UNCORRECTED:

Distance	Near
Visual Acuity	Visual Acuity
Right: 20 /	Right: 20 /
Left: 20 /	Left: 20 /
Both: 20 /	Both: 20 /

CORRECTED:

Distance	Near
Visual Acuity	Visual Acuity
Right: 20 /	Right: 20 /
Left: 20 /	Left: 20 /
Both: 20 /	Both: 20 /

Diagnosis from Vision Testing / Refraction:

Myopia: ( ) Mild ( ) Moderate ( ) High
Hyperopia: ( ) Mild ( ) Moderate ( ) High
Astigmatism: ( ) Mild ( ) Moderate ( ) High

Eye Health Status: ( ) Normal ( ) Abnormal

Color Vision:

Right: # Correct _____ out of # Possible _____
Left: # Correct _____ out of # Possible _____

Does This Child Need Glasses: ( ) No ( ) Yes
If Yes: ( ) Constantly
( ) Reading
( ) Distance

Visual Abilities:

Eye Teaming: ( ) Adequate ( ) Inadequate
Convergence Ability: ( ) Adequate ( ) Inadequate
Focusing Ability: ( ) Adequate ( ) Inadequate
Stereopsis (3D): ( ) Adequate ( ) Inadequate

Examining Eye Doctor's Name: _____

Address: _____ **Phone**: _____

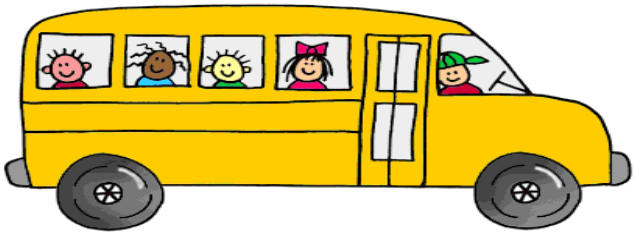
Date of Exam: _____ **Follow Up Appointment**: _____

Disclosure of the information noted above is necessary to comply with the statutory purpose as outlined in s.118.135, Wis. Stats.
11/27/2019

IMMUNIZATION REQUIREMENTS

Parents, Do not let your child get left behind!

These are the minimum required immunizations for each school age/grade level. Not for children under the age of 2.



This Photo by Unknown Author is licensed under CC BY

A child, Ages 2-4, entering Pre-School, 4K or Head Start → **Needs**

- 4 Diphtheria/Tetanus/Perussis (DTaP)
- 3 Polio
- 1 Varicella (chickenpox)
- 1 Measles/Mumps/Rubella (MMR)
- 3 Hepatitis B

A student entering 5K through Gr. 5 → **Needs**

- 4 Diphtheria/Tetanus/Perussis (DTaP)
- 4 Polio
- 2 Varicella (chickenpox)
- 2 Measles/Mumps/Rubella (MMR)
- 3 Hepatitis B

A student entering Gr. 6 through Gr. 12 → **Needs**

- 4 Diphtheria/Tetanus/Perussis (DTaP)
- 1Tdap
- 4 Polio
- 2 Varicella (chickenpox)
- 2 Measles/Mumps/Rubella (MMR)
- 3 Hepatitis B

1. DTP/DTap/DT vaccine for children entering Kindergarten: Your child must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant. (Note: a dose 4 days or less before the 4th birthday is acceptable).
2. DTP/DTap/DT vaccine for children entering Pre-K and grades 1 through 12: Four doses are required. However, if your child received the 3rd dose after their 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is acceptable).
3. Tdap means adolescent tetanus, diphtheria and acellular pertussis vaccine. If your child received a dose of a tetanus-containing vaccine, such as Td, within 5 years of entering the grade in which Tdap is required, your child is compliant and a dose of Tdap is not required.
4. Polio vaccine for students entering grades 5K through Gr. 12: Four doses are required. However, if your child received the 3rd does after their 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is acceptable).
5. The first dose of MMR vaccine must have been received on or after the first birthday. (Note: a dose 4 days or less before the 1st birthday is acceptable).

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 6/2020)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

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)	Telephone Number

Step 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A **(√)** OR **(X)** except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

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 *Vaccine is required only if your child has not had chickenpox disease. See below:*					

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:	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)
☐ YES _____ Year (Vaccine not required)	☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
☐ NO or Unsure (Vaccine required)	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

☐ **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

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