Elkhorn Area School District

Tradition • Innovation • Distinction

MIDDLE SCHOOL & HIGH SCHOOL STUDENT PHYSICAL REPORT FORM

The EASD requests a physical examination for 4K/5K, 4th, 7th, and 9th grade students, and for all new students entering the district. This is done to encourage a lifetime of health behaviors, detect any abnormalities, and to promote full participation in activities. WIAA rules require a current physical every two years. A current physical must be at school on the first day of sports practice for youth participation.

Name _____ Grade _____

Date of Birth _____ School _____

Chronic Health Diagnosis _____
Routine Medications and Rational _____
Allergies (Specific type and reaction) _____
Concussion or Lead Exposure History _____

☐ Sports Physical
(*the attached WIAA Athletic Permit Card must also be signed by your physician and submitted to your student's school)*

Posture/Scoliosis _____
Neuro-muscular _____
Head/Neck _____
Acanthosis nigricans ☐ No ☐ Yes
Ears/Nose/Throat _____
_____
Dental Cavities ☐ No ☐ Yes
Heart _____
Lungs _____
Abdomen _____
Genito-Urinary _____
Lymph Nodes _____
Hernias _____
Limitations of Activity _____
_____

Height _____ Weight _____ B/P _____/_____
Vision Screening with Snellen

Right	Left	Both
20/___	20/___	20/___

Glasses ☐ No ☐ Yes ☐ Reading ☐ All Times
Urine (optional) _____
Glucose _____
Albumin _____
H&H (optional) _____
Tb Skin Test (PPD or Mantoux)(optional) _____
Psychological Stability _____
Concerns _____
Overall _____
_____
_____

_____ _____ _____
Physician's signature Date Physician's Address & Phone or Stamp

SEE PAGE 2 FOR IMMUNIZATION RECORD

Elkhorn Area Middle School
627 E. Court Street
Elkhorn, WI 53121
262-723-6800 (ph)
262-723-4967 (fx)

Elkhorn Area High School
482 E. Geneva Street
Elkhorn, WI 53121
262-723-4920 (ph)
262-723-8092 (fx)

OPtions Virtual Charter School
534 Sunset Drive
Elkhorn, WI 53121
262-723-1696 (ph)
262-723-4652 (fx)

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 06/2017)

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 be waived only 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 law and will be used for that reason only. If you have questions regarding immunizations, or how to complete this form contact your child's school or local health department.

PERSONAL DATA **PLEASE PRINT**

Step 1

Student's Name	Birthdate (Mo/Day/Yr)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number ( )

IMMUNIZATION HISTORY

Step 2

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 Mo/Day/Yr	SECOND DOSE Mo/Day/Yr	THIRD DOSE Mo/Day/Yr	FOURTH DOSE Mo/Day/Yr	FIFTH DOSE Mo/Day/Yr
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) ☐ NO or Unsure (Vaccine required)	☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B If YES, provide laboratory report(s)

REQUIREMENTS

Step 3

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

COMPLIANCE DATA

Step 4

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 THE DISEASES OCCURS.

☐ Although my child has NOT received ALL 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

SIGNATURE

Step 5

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

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

WISCONSIN INTERSCHOLASTIC ATHLETIC ASSOCIATION – ATHLETIC PERMIT CARD

(Print or Type)

ALL STUDENTS PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

Physical examination taken April 1 and thereafter is valid for the following two school years; physical examination taken before April 1 is valid only for the remainder of that school year and the following school year.

NAME (Last) _____ (First) _____ (Middle Initial) _____ Date of Birth _____

Age _____ Sex _____ Grade _____ School _____ City _____

Present Address _____ Telephone _____

❑ **Cleared without restriction** ❑ **Cleared, with the following qualifications:** _____

_____

❑ **Not cleared** ❑ **Pending further evaluation** ❑ **For all sports** ❑ **For certain sports:** _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician (Print/Type) _____

SIGNATURE OF LICENSED PHYSICIAN (MD OR DO)/PA/APNP*: _____

Clinic Name _____

Address/Clinic _____ City _____ State _____ Zip Code _____

Telephone _____ Date of Examination _____

* Physicians may authorize Nurse Practitioners to stamp this card with the physician's signature or the name of the clinic with which the physician is affiliated.

Parents' Place of Employment _____

Family Physician _____ Family Dentist _____

Name of Private Insurance Carrier _____ Telephone _____

Subscriber Member Name (Primary Insured) _____

Emergency Information

Allergies _____

Other Information (medication, etc.) _____

Immunizations ❑ **Up to date (see attached documentation)** ❑ **Not up to date - specify** _____
(e.g., tetanus/diphtheria; measles, mumps, rubella; hepatitis A, B; influenza; poliomyelitis; pneumococcal; meningococcal; varicella)

1. I hereby give my permission for the above named student to practice and compete and represent the school in WIAA approved interscholastic sports except those restricted on this card.

2. Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively known as "HIPAA"), I authorize health care providers of the student named above, including emergency medical personnel and other similarly trained professionals that may be attending an interscholastic event or practice, to disclose/exchange essential medical information regarding the injury and treatment of this student to appropriate school district personnel such as but not limited to: Principal, Athletic Director, Athletic Trainer, Team Physician, Team Coach, Administrative Assistant to the Athletic Director and/or other professional health care providers, for purposes of treatment, emergency care and injury record-keeping.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

IMMUNIZATION REQUIREMENTS BY AGE/GRADE LEVEL

The following are the minimum required immunizations for each age/grade level according to the Wisconsin Student Immunization Law. Additional immunizations may be recommended for your student depending on his/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 (2 through 4 years)	4 DTaP/DTP/DT2		3 Polio	3 Hep B[6]	1 MMR[7]	1 Varicella[8]
Kindergarten through Grade 5	4 DTaP[1]/DTP/DT/Td[2,3]		4 Polio[5]	3 Hep B[6]	2 MMR[7]	2 Varicella[8]
Grades 6-12	4 DTaP/DTP/DT/Td[2]	1 Tdap[4]	4 Polio[5]	3 Hep B[6]	2 MMR[7]	2 Varicella[8]
Pre-College Recommended Vaccination:	MENINGITIS					
Other Vaccinations:	Flu, Pneumonia, HPV					

[1] Children > 4 years of age who are in 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. 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 adolescent tetanus, diphtheria and acellular pertussis 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 first birthday. Note: A does four days or less before the 1st birthday is also acceptable. Laboratory evidence of immunity to all three diseases (measles and mumps and rubella) is also acceptable.
[8] Varicella vaccine is chickenpox vaccine. A history of chickenpox disease or laboratory evidence of immunity to varicella is also acceptable.