



June 2009

Dear WIS Parents,

To ensure the safety of each child at WIS, the personnel at WIS need to have a record of every child's health history available for field trips, emergency situations, and day-to-day activities. The medication and health information forms enclosed need to be completed and returned to WIS before August 21, 2009. All forms are confidential and access will be limited to only those WIS personnel who need to be directly involved in the medical care of students.

Please follow the guidelines listed below:

1. Every student needs to have a medical report form completed and signed by a parent or guardian.
2. A physicians' health appraisal needs to be completed and have a current signature from the physician.

Thank you for your attention to these important forms.

Sincerely,

Stanley Way
Head of School

Medical Report

School Year 2009-2010

Confidential to WIS

Student Name: _____

Grade: _____ Birth date: _____

Section 1 – General Health Information

Condition	Yes /No	Start Date	Condition	Yes/No	Start Date
Allergies - Food			Bleeding Problems		
Allergies – Drugs			Seizures		
Allergies – Other			Vision Problem		
Asthma			Hearing Problems		
ADHD/ADD			Surgeries		
Psychosocial			Fractures		
Diabetes			Other Conditions		
Heart Problems			Diet Restrictions		Medical reason-
Musculoskeletal			Diet Restrictions		Personal choice-

If you indicated yes to any of these conditions, please explain _____

Other conditions or additional information regarding your child's health: _____

Is your child taking any medication? Yes _____ No _____ If "Yes" please specify current medications – name, dosage, frequency: _____

Signature _____ Date _____

Section 2 – Physician Health Assessment

Student Name: _____ Birth date: _____

Last Assessment Date: ____/____/____

Weight: _____ Height: _____ BMI _____

Hearing: _____ Normal _____ PE tubes _____ Eval Needed

Vision _____ Normal _____ Glasses _____ Eval Needed

Allergies Food: _____ Insects: _____ Medications: _____

Type of allergic reactions: Anaphylaxis _____ Local Reaction _____

Response Required? _____ None _____ Call MD

_____ Epi Pen (Dose, route, frequency)

Conditions identified that are important to schooling or physical activity (eg. Asthma, diabetes, heart problems, bleeding problems, musculoskeletal issues, seizure disorder, psychosocial problems, hyperkinesia, etc) _____

Special Diet: _____

Any additional comments: _____

Activity Level _____ Full _____ Limited

Physician's signature: _____

Print Name: _____

Phone number: _____ Date _____

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 the law and will be used for that reason only. If you have questions on 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						
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. 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) <input type="checkbox"/> Tdap <input type="checkbox"/> Td						
Polio						
Hepatitis B					*Hib vaccine is only required for children in licensed day care centers. Do <u>not</u> report the dates your child received Hib vaccine on this form.	
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: <input type="checkbox"/> YES _____ year (Vaccine not required) <input type="checkbox"/> NO or Unsure (Vaccine required)						

REQUIREMENTS

Step 3 Refer to the age/grade level requirements for the current school year to determine if this student meets the 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 THESE 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 and notify the school may result in court action and a fine of up to \$25.00 per day of violation.

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 this student should not be immunized.

For personal conviction reasons this student should not be immunized.

LIST VACCINE(S) WAIVED _____

SIGNATURE

Step 5 This form is complete and accurate to the best of my knowledge.

 SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student Date Signed

Authorization to use and disclose medical information

2009-2010 School Year

Right to revoke authorization: I understand that I have the right to revoke this authorization, except to the extent that my doctor or other health care provider has already used or disclosed my medical information in reliance on this authorization. I understand that my revocation is effective only if it is in writing. To revoke my authorization, I understand that I must send a written request for revocation to medical records department of my physician's office.

My medical information may be disclosed: I understand that if my medical information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by a person who has received my medical information. I understand that this re-disclosure may not be protected by the applicable privacy laws.

Right to inspect and copy medical information: I understand that I have the right to inspect and copy certain medical information in my doctor or other health care provider's records as provided by law.

I understand that to inspect and copy medical information, I must submit my request in writing to the medical records department of my health-care provider. If I request a copy of the information, I understand that the doctor or other health care worker may charge a fee for the costs of copying, formatting, or other supplies associated with my request.

I understand that the doctor or other health care provider may deny my request to inspect and copy in certain, but very limited circumstances. If I am denied access to medical information, I may request that the denial be reviewed.

I am not required to sign this authorization. I understand that I may refuse to sign this authorization. I understand my doctor or other health care provider will not require me to sign this form in order to obtain treatment.

Right to receive a copy of this authorization. I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

Disclosure of direct or indirect payment received by any person or organization authorized to use or disclose my health information. I understand that neither the discloser nor the recipient of information disclosed pursuant to the authorization will be receiving any direct or indirect payment in connection with the use or disclosure of my health information other than copying costs.

Expiration Date: This authorization will remain in effect until the following date: June 30, 2010.

Acknowledgement and right on condition physical examination on authorization:

I understand that my doctor or other health care provider must create medical records containing confidential medical information about me. By signing this form, I am authorizing the health care provider named on the reverse to disclose my medical information to the Wisconsin International School for the purpose of determining fitness for participation in the school activities.

I understand that where my health care provider is examining me for the sole purpose of determining my fitness for participation in Wisconsin International School activities, my health care provider may condition such examination on my signature below. I further understand that my health care provider may not otherwise condition examination or treatment on my signature below.

Child's Name

Signature of Parent or Legal Guardian

Date