SEYMOUR COMMUNITY SCHOOL DISTRICT

Black Creek Elementary
308 East Burdick Street, PO Box237
Black Creek, WI 54106
920-984-3396 Fax: 920-984-9303

Rock Ledge Primary Center
330 West Hickory Street
Seymour, WI 54165
920-833-5155 Fax: 920-833-5144

Check box to indicate the grade your child will be attending. ☐ **4K** ☐ **5K**

Child's Name_____ Birth Date _____

Parent or Guardian _____

School child will be attending _____

TO THE PARENT: We urge you to take your child to the doctor before school begins for an examination and any recommended care. When the examination is completed, **please return this form to the school**.

The information below is to be completed by the Physician.

HT _____WT _____B/P_____

OTHER VS OR LAB _____

Results of hearing screening, if done

_____

_____

Complete the back side of this form for the vision screening, if done.

GENERAL APPEARANCE

_____

SKIN_____ EYES_____ EARS_____ NOSE_____

MOUTH_____ THROAT_____ TEETH_____

RESPIRATORY_____

CARDIOVASCULAR_____

GASTROINTESTINAL_____

GENITOURINARY_____

MUSCULAR / SKELETAL _____

NEUROLOGICAL_____

1. Does this child have a health concern which may require EMERGENCY ACTION while he or she is at school? (e.g. seizure disorder, diabetes, heart problem, severe asthma, bleeding problem, bee sting or severe food allergy) ☐ No ☐ Yes If yes, please describe.

_____

2. List any allergies and specific reactions:

_____

3. Are any allergies LIFE-THREATENING? ☐ No ☐ Yes If yes, please describe.

_____

4. Does child need an EPI Pen? ☐ No ☐ Yes

5. Is this child on medication? ☐ No ☐ Yes If yes, please list medication/s, dosage and frequency.

****** A medication order form must be completed for school staff to administer medication at school.***

_____

6. Are there any restrictions of physical activity or physical education in school? ☐ No ☐ Yes (describe nature, duration)

_____

7. Does the child need special nutritional consideration? ☐ No ☐ Yes (please describe)

_____

8. Do you want the school nurse to contact you regarding this child? ☐ No ☐ Yes

9. Are there any other significant findings on exam, health history, or review of systems that may impact this child's health or learning during the school years?

☐ No ☐ Yes (please describe) _____

_____

Any Additional Comments: _____

Examiner's signature_____ Exam date _____

Printed name of examiner _____

Address and phone # of examiner_____

PLEASE RETURN THIS FORM TO THE SCHOOL (address listed above). Thank you **1/2014**

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_____

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 not 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.