# SCHOOL DISTRICT OF BRUCE

*For Office Use Only*

Enrollment Date______________ Grade __________ Student Number _________________

Lunch ID # ________________ Family ID # ______________ WISE ID___________________

Bus______________ Miles From School_____________ Kindergarten Birth Certificate Verification_________

Student Name _______________________________________________________________________________

*Last* *First* *Middle* *Grade*

Student Date of Birth _________ ***IF there are siblings younger than four years old in the household, please fill out the census form.***

**Student Primary Household:** ______________________________ ________________ ________________

(RESIDES WITH) *Parent/Legal Guardian* *Home Phone* *Cell Phone*

______________________________ ________________ ________________

*Employment* *Work Phone* *Email*

______________________________ ________________ ________________

*Parent/Legal Guardian* *Home Phone* *Cell Phone*

______________________________ ________________ ________________

*Employment* *Work Phone* *Email*

Primary Mailing Address____________________________________________________________________________

City ______________________________________________ State __________ Zip Code __________________

Primary **Bus** Street Address_______________________________________________________________________

**Student Secondary Household:**___________________________ ________________ ________________

*Parent/Legal Guardian* *Home Phone* *Cell Phone*

______________________________ ________________ ________________

*Employment* *Work Phone* *Email*

______________________________ ________________ ________________

*Parent/Legal Guardian* *Home Phone* *Cell Phone*

______________________________ ________________ ________________

*Employment* *Work Phone* *Email*

Secondary Mailing Address__________________________________________________________________________

City______________________________________________State___________Zip Code__________________

Ethnic/Racial Category ___Asian ___American Indian ___Black ___Hispanic
___White ___Native Hawaiian or Other Pacific Islander

# Bruce School Census Information

Family Name______________________________

Address_________________________________ Phone______________

Please list all children living in the household under the age of four years old:

| Child's Name | Current Age | Birthdate |
|---|---|---|
| | | |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

# *School District of Bruce*

**104 W. Washington Ave., Bruce, WI 54819**

Central Office: 715/868-2585 District Office: 715/868-2533 Auto Attendant: 715/868-2598 FAX: 715/868-2534

**Date:**________________________________________

**School Formerly Attended:** ____________________________________________

____________________________________________

____________________________________________

The following student(s) has/have enrolled in the *Bruce School District.*

| Name | D.O.B. | Grade Entering |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please forward by IMMEDIATE FAX to 715-868-2534:** Most recent report card or withdrawal grades, transcript, current IEP (if applicable). **You may also email** Jeanne at: **weisser@bruce.k12.wi.us** OR Lori at: **lorisue@bruce.k12.wi.us**

**Has this student been expelled?**_______________

**Please forward by mail:** All school cumulative records including report cards, transcripts, individual education plan (IEP), medical and immunization records, Wisconsin WIAA physical card (if applicable) to:

Bruce Public School
Attn: Jeanne or Lori
104 West Washington Avenue
Bruce, WI 54819

The above student has enrolled in our school district. Per Wisconsin Statute 118.125 (4), written parental consent is no longer required to release records between schools or school systems. A school district shall transfer records within five working days of this request for records. **Thank you for your help. If questions, please call 715-868-2585.**

____________________________________________

Brad Cody, Middle/High School Principal / Carrie Wessman, Elementary Principal/Curriculum Director

# SCHOOL DISTRICT OF BRUCE

## Student and Emergency Contact Information

### Student Information

| Student Name | Date of Birth | Gender ☐ Male ☐ Female |
|---|---|---|
| Address | | |

### Parent/Guardian Information

| Parent/Guardian 1 | Parent/Guardian 2 |
|---|---|
| Address (if different from student) | Address (if different from student) |
| Email | Email |
| Home phone | Home phone |
| Cell phone | Cell phone |
| Place of employment | Place of employment |
| Work phone | Work phone |

### Emergency Contact Information

| Emergency contact 1 | Emergency contact 2 |
|---|---|
| Relationship to student | Relationship to student |
| Email | Email |
| Address | Address |
| Home phone | Home phone |
| Cell phone | Cell phone |
| Place of employment | Place of employment |
| Work phone | Work phone |

I understand that if my child becomes ill or injured at school an attempt to reach parents/guardians will be made. If unable to reach parents/guardians then an attempt to reach emergency contacts will be made. I agree that my child needs to be picked up at the discretion of the school district and must be picked up in a timely manner. I give permission for my child to leave school with those listed above.

Parent/Guardian Signature:______________________________________ Date:________________

# BLANKET PERMISSION SLIP

My child ________________________________ has my permission to go on educational trips *within the school district* during the school year.

***This form will only need to be completed one time while your child is in the Bruce Elementary School.***

Signature ________________________________

# BRUCE SCHOOL PICTURE/VIDEOTAPE PERMISSION FORM

During the school year there are many occasions when students have their picture taken or are videotaped during an activity. These pictures are sometimes printed in the newspaper and the videotape may be shown on the public access channel (Channel 57) of the local cable system or through another public access channel.

Please indicate below your preference in having the pictures and videotape of your child shown through the media. <u>This form will only need to be completed one time while your child is in the Bruce Elementary School.</u> If you have any questions or concerns, please call Ms. Wessman/Elementary Principal, or Mr. Cody/High School-Middle School principal, at the school office.

---

______________________________

**STUDENT NAME**

________ I give permission for my child to be photographed and/or videotaped. These pictures may be used in an educational and/or newsworthy manner.

________ I do not give permission for my child to be photographed and/or video taped.

________________________________________ ____________

**PARENT/GUARDIAN SIGNATURE** **DATE**

## Elementary Respectful Behavior Promise

Inappropriate and intimidating behavior is when someone constantly uses words or actions meant to harm, hurt, or intimidate others.

This includes:

- Unacceptable behavior on the bus or on school grounds
- Using electronic devices or the internet to spread untruths about others often
- Harming or hurting others physically or emotionally consistently
- Threatening or intimidating others repeatedly
- Intentionally leaving others out or encouraging isolation/separation of said student over and over

**Pledge of Respect and Trust in Our Community and School:**
We believe that everybody should enjoy our school equally, and feel safe, secure and accepted regardless of what they look like, where they came from, what skills or talents they show inside and outside of the classroom-such as athletic ability or interests, popularity, or any other differences.

As part of my community and my school, I pledge to:

- Treat others respectfully
- Try to include those who are left out, and respect that everyone has different interests and talents
- Refuse to participate in mistreating others
- Refuse to watch, laugh, or join in when someone is mistreating others
- Refuse to swear or use hurtful words toward others
- Be an active bystander, stand up for those being mistreated or tell an adult
- Be safe toward others (No hitting, punching, kicking, or throwing harmful objects)
- Be sensitive and caring towards others and don't disrupt the learning environment
- Be respectful of other student's personal space
- Not irritate or annoy a fellow classmate on purpose in order to cause a negative response from the student

**Student's responsibility:** "I will not mistreat or hurt my fellow classmates or others and understand that if I do join in this type of behavior, I will have to face the situation and restore or repair any damage or harm. If I notice mistreatment or any other inappropriate behavior, I will tell an adult or person in charge of the activity or event."

**Parent's responsibility**: "I will discuss any situations of inappropriate behavior, and I will report any concerns I have with the way my child is being treated, or if my child reports possible mistreatment of others. I will also encourage my child to communicate with their classmates, and let them know when they feel hurt or disrespected. I will empower my child to stand up for themselves and others, and get help from an adult if needed."

Student Signature ______________________________________________

Parent Signature _______________________________________________

# PLEASE KEEP THIS PAGE FOR YOUR REFERENCE AT HOME

## BLANKET PERMISSION SLIP

The Blanket Permission Slip gives your child permission to go on educational trips *within the school district* during the school year. Teachers will send information home about these field trips, but will not require another permission slip.

****************************************************************************************

## PHOTOGRAPH/VIDEO PERMISSION

During the school year there are many occasions then students have their picture taken or are videotaped during an activity. These pictures are sometimes printed in the newspaper or school newsletter. This gives the school permission to use these in an educational and/or newsworthy manner.

****************************************************************************************

## BRUCE SCHOOL RESPECTFUL BEHAVIOR PLEDGE

As part of my community and my school, I pledge to:

- Be a part of the solution;
- Do my part to make my school and community a safe place by being more sensitive to others;
- Eliminate taunting from my own behavior;
- Encourage others to do the same;
- Set the example of being a caring individual;
- Eliminate profanity toward others from my language;
- Not let my words or actions hurt others;
- I WANT TO BE PART OF THE SOLUTION, I WILL RESTORE OR REPAIR ANY DAMAGE OR HARM!

What is inappropriate and intimidating behavior?

- Intentional, unprovoked efforts to harm
- Repeated negative action by one or more students against another
- Spreading rumors, teasing, name calling, insults, coercion, and exclusion
- Pushing, kicking, hitting, battering, stealing, breaking possessions, aggression, intimidation
- Using social media as a platform to intentionally offend or harm others

Student Name ______________________________ Grade ______

# BRUCE SCHOOL SIGNATURE FORM

The following items are necessary for parental permission for students on a yearly basis. Please read the attached forms for information about each one, then initial by each item you give permission for and sign at the bottom of this form. Thank you.

**************************************************************************

Blanket Permission Slip ___________

This is to allow your child to go on educational trips within the school district during the school year. This form will only need to be completed one time while your child is in Bruce Elementary School.

**************************************************************************

Photograph/Video Permission ___________

This is to allow for your child to be photographed and/or videotaped during activities at school. The pictures may be used in an educational and/or newsworthy manner.

**************************************************************************

Respectful Behavior Promise

This is to agree to the school respectful behavior promise – to be a part of the solution against mistreatment of others at the Bruce School. Your child's signature is required.

Student Signature ________________________________

**************************************************************************

There may be other forms necessary for school record purposes in addition that need to be signed and submitted separately from this form. Thank you for helping us with this process.

I have reviewed the agreements listed above and, by signing below, agree with the contents of those documents.

Parent/Guardian Signature _____________________________________________

Date _____________________

# USDA Non-Discrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:

**1. mail:**
U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410; or

**2. fax:**
(833) 256-1665 or (202) 690-7442; or

**3. email:**
program.intake@usda.gov

This institution is an equal opportunity provider.

05/05/2022

| For ESL Use Only |
|---|
| ESL Test Date______________ |
| ESL Evaluator______________ |
| ESL Level______________ |

*School District of Bruce*

| Designated Staff: Initial in box after reviewing form for check marks in any of the first seven questions. ☐ |
|---|

# HOME LANGUAGE SURVEY

## TO BE COMPLETED FOR ALL NEW STUDENTS

**The completion of a HomeLanguage Survey is a requirement under WI Statutes PI 13 for all districts in the state of Wisconsin. Your cooperation in providing the following information is appreciated.**

---

| Student's Name: | Date of Birth: | Grade/School Location: |
|---|---|---|
| Address: | Work Phone Number: | Home Phone Number: |

**Relationship of Person Completing Survey**

☐ Mother ☐ Father ☐ Guardian ☐ Other *Specify*______________________

**Directions: Check the correct response for each of the following questions and indicate other languages if appropriate.**

| | ENGLISH | OTHER | NAME OF LANGUAGE |
|---|---|---|---|
| **1.** What language did the student *learn when he or she first began to talk*? | ☐ | ☐ | ______________ |
| **2.** What language does the family speak at home *most of the time?* | ☐ | ☐ | ______________ |
| **3.** What language(s) does the student *hear and understand in the home*? | ☐ | ☐ | ______________ |
| **4.** What language does the parent(s) speak to her/his child *most of the time?* | ☐ | ☐ | ______________ |
| **5.** What language does the student speak to his/her parents *most of the time?* | ☐ | ☐ | ______________ |
| **6.** What language does the student speak to his/her friends *most of the time?* | ☐ | ☐ | ______________ |
| **7.** What language does the student speak to his/her brothers and sisters *most of the time?* | ☐ | ☐ | ______________ |

| | Yes | No | Other? |
|---|---|---|---|
| **8.** Can an adult family member or extended family member speak English? | ☐ | ☐ | ______________ |
| **9.** Can an adult family member or extended family member read English? | ☐ | ☐ | ______________ |
| **10.** Do the parents/guardians request oral and/or written communication from the school to be in English ? | ☐ | ☐ | |

**If no**, in what language? ______________

**Name of Person Completing Survey:** ______________________________ **Date Signed:** ______________

(PLEASE PRINT CLEARLY)

# *School District of Bruce*


**104 W. Washington Ave., Bruce, WI 54819**

Central Office: 715/868-2585 District Office: 715/868-2533 Auto Attendant: 715/868-2598 FAX: 715/868-2534


Dear Parents:

With this new year beginning, we would like to remind everyone about the rules regarding the computerized lunch program.

The program operates as follows:

1. Each student will be issued a laminated I.D. card (for which he/she will be responsible). This card will be used throughout the entire year. When the student goes through the lunch line, the student will present their card to the scanner. When the computer reads the card, one meal will automatically be counted for the student. The district food service program will operate under the Community Eligibility Provision, or CEP. The CEP program provides one free breakfast and one free lunch for every student. You may call the school office anytime to get information on your lunch account. Please call Jeanne Weisser at 715-868-2585 ext. 225.

2. Students who wish to purchase *additional* lunches or *extra* milks may do so. Elementary school students must bring the scanner a note from home allowing this transaction to take place. There is one lunch account for each family. When the student's family account reaches $10.00 dollars, they will be verbally told that their account is reaching a low balance. Grade school students will also receive a red stamp reading "LUNCH MONEY". The purpose of this stamp is to aid the students in remembering to discuss needed lunch money with the appropriate person at home. A waiver may be obtained by contacting the school if you prefer for your children not to be stamped. Upon this request, you will be taking the responsibility to keep track of your lunch account balance to be sure your students have money to purchase additional items. Every student will be charged full price for an additional meal or milk. The only item covered under the CEP program is the first reimbursable meal.

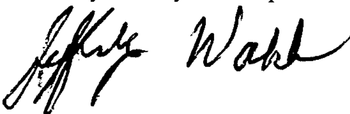
3. If a student loses their lunch card, a new one may be obtained. The cards for elementary school students will be collected by their teacher on a daily basis. We encourage middle/high school students to keep their cards in their wallet or purse. Two replacement cards will be furnished to any student. A .50 charge will be collected for any number above that for cards lost, stolen, or destroyed.

4. Paid, Free, Reduced, and Staff lunch cards will all be handled in the same manner. All information regarding the accounts is confidential.

5. A student whose lunch account is depleted of funds, will not be allowed to purchase any additional meal or milk.

This system has had a very positive effect for the School District of Bruce, and has many advantages. We encourage any questions you may have, and ask that you call 715-868-2585 for information.

Thank you for your cooperation.



Mr. Jeffrey Walsh

District Administrator

***Vision: The Bruce School District provides a student-centered environment with educational opportunities inspiring students to achieve their full potential.***

***Mission: The Bruce School District strives to create a collaborative learning community focused on results promoting student growth.***

# *School District of Bruce*

**104 W. Washington Ave., Bruce, WI 54819**

Central Office: 715/868-2585 District Office: 715/868-2533 Auto Attendant: 715/868-2598 FAX: 715/868-2534

Dear Parents/Guardians:

Welcome to the Bruce School District. The health of your child is very important to us. In order to best meet your child's needs we ask that you provide specific health information about your child. This letter also contains information for you regarding health and medical care at school.

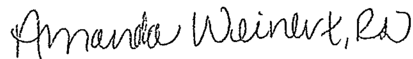
We recommend all children have a medical, dental, and vision examination prior to the start of Kindergarten. If your child has certain medical conditions or requires medication at school additional information will be needed. The school district does not purchase any over-the-counter (OTC) medications for general use. If your child needs any OTC or prescription medication at school you must provide this and complete the appropriate authorization forms.

Students must be in compliance with Wisconsin school immunization requirements. Please provide the school with your child's immunization record, including the date each vaccine was administered. Vaccine waivers are available for health, religious, and personal conviction reasons. However, in the event of an outbreak of a vaccine preventable disease, students with waivers may be excluded from school until the outbreak subsides. I encourage you to have your child's immunizations completed as soon as they become due.

If your child is ill please keep them home from school. Children who have a fever, vomiting, or diarrhea should be free of these symptoms for 24 hours, without the use of medication, before returning to school. Children who are coughing should also remain home from school. You may be asked to provide a medical note for your child to return to school. It is very important that school staff are able to contact someone if your child becomes ill or injured while at school. Please provide us with contact information for yourself and for emergency contacts. Children need to be picked up from school in a timely manner when needed. Remember to keep contact information updated with our school office if changes occur.

Enclosed you will find forms to provide us with this important health information. If you have questions please contact me at 715-868-2585. I look forward to working with you and your child as they begin their great adventure of learning here at the Bruce School.

Respectfully,



Amanda Weinert, RN
School Nurse

## 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.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (02/2023)

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) | Phone Number |
|---|---|---|
| | | |

**Step 2** IMMUNIZATION HISTORY

List the MONTH, DAY, AND YEAR your child received each of the following immunizations.. If you do not have an immunization record for this student, contact your doctor or public health department to obtain it. You may also use the Wisconsin Immunization Registry: https://www.dhfswir.org/PR/clientSearch.do?language=en

| 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 if your child has not had chickenpox disease. See below* | | | | | |
| **Meningoccocal** (serogroup ACWY) | | | | | |

Students with a reliable history of varicella disease are not required to receive the varicella vaccine. Signature from physician, physician assistant, or advanced nurse prescriber required.
☐ I attest that this student has a reliable history of varicella disease,

SIGNATURE – Healthcare Provider Date Signed

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)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
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 ☐ MenACWY

☐ **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 ☐ MenACWY

**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

715-868-2585

**School District of Bruce**

HOME of the RED RAIDERS

# PRESCHOOL / KINDERGARTEN MEDICAL EXAMINATION

TO BE COMPLETED BY A HEALTHCARE PROVIDER

## STUDENT INFORMATION

| | |
|---|---|
| STUDENT NAME: | DATE OF BIRTH (mm/dd/yyyy): |
| PARENT / GUARDIAN NAME(S): | SCHOOL ATTENDING: |
| HEALTHCARE PROVIDER: | DATE OF EXAMINATION: |

## IMMUNIZATIONS

Attach a copy of the immunization record.

## PERTINENT ILLNESS, COMMUNICABLE DISEASES, RISKS, OR DEVELOPMENT PROBLEMS *Please check all that apply.*

| | | |
|---|---|---|
| [ ] ALLERGIES *If yes, please list:* | [ ] ASTHMA | [ ] ATTENTION / LEARNING |
| [ ] BLEEDING DISORDER | [ ] CANCER/LEUKEMIA | [ ] CEREBRAL PALSY |
| [ ] CHICKEN POX *If yes, date:* | [ ] CYSTIC FIBROSIS | [ ] DENTAL PROBLEMS |
| [ ] DIABETES | [ ] EMOTIONAL / BEHAVIORAL | [ ] ENCOPRESIS |
| [ ] ENURESIS | [ ] GENETIC DISORDERS | [ ] HEART CONDITIONS |
| [ ] HEARING DISORDER | [ ] HEPATITIS | [ ] KIDNEY DISORDER |
| [ ] LEAD LEVEL *If yes, test done:* [ ] YES [ ] NO *At risk:* [ ] YES [ ] NO | [ ] OBESITY | [ ] ORTHOPEDIC CONDITION |
| [ ] PNEUMONIA | [ ] SEIZURE / CONVULSIONS | [ ] SICKLE CELL ANEMIA |
| [ ] SPEECH / LANGUAGE | [ ] TUBERCULOSIS | [ ] VISION |

[ ] OTHER *If yes, please list:*

[ ] COMMENTS *If yes, please explain all that apply:*

## PHYSICAL EXAMINATION

| | NORMAL | ABNORMAL |
|---|---|---|
| GENERAL APPEARANCE | [ ] | [ ] |
| HEENT | [ ] | [ ] |
| SKIN | [ ] | [ ] |
| NECK | [ ] | [ ] |
| CHEST | [ ] | [ ] |
| HEART | [ ] | [ ] |
| ABD/GENITALIA | [ ] | [ ] |
| MUSCULOSKELETAL | [ ] | [ ] |
| NEURO | [ ] | [ ] |

HEIGHT:

WEIGHT:

BLOOD PRESSURE: /

HEARING: R L

VISION: R L

*Optional:*

HCT/HGB:

UA:

TB TEST *Date:*

*Type:* *Results:*

## SUMMARY OF FINDINGS

[ ] WELL CHILD; NO CONDITIONS IDENTIFIED OF CONCERN

[ ] CONDITIONS IDENTIFIED THAT ARE OF CONCERN TO SCHOOL AND/OR PHYSICAL ACTIVITY
*Complete sections below and explain here:*

[ ] INDIVIDUAL HEALTH PLAN NEEDED

[ ] SPECIAL DIET REQUEST FORM

[ ] PHYSICAL EDUCATION EXCUSE

[ ] MEDICATION ORDER FORM

[ ] ASTHMA MEDICATION ORDER FORM

[ ] ALLERGY / ASTHMA ACTION PLAN

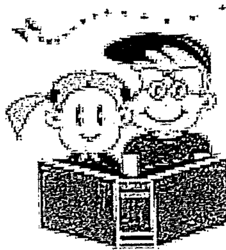
## PROVIDER INFORMATION

| | | |
|---|---|---|
| PROVIDER'S NAME: | PHONE: | |
| ADDRESS: | CITY: | ZIP: |

PROVIDER'S SIGNATURE

DATE

NOTE: If you wish to save data typed into this form, first save the file on your computer and re-open from your computer prior to typing.

# Clear Vision,  Bright Future!

**What every parent should know for good vision and healthy eyes:**

- 80 percent all learning during a child's first 12 years of life is obtained through vision.
- Vision disorders are the 4th most common disability in the United States and the most prevalent handicapping condition in childhood.
- 8 to 12 million school age children are at risk from undetected vision impairments.

The bottom line is: Your child's ability to see clearly in school will have an enormous impact on their ability to learn. As parents, you can ensure that your child's academic performance is maximized from the beginning of their educational career by having their eyes tested. Undiagnosed and, therefore, untreated vision problems among our children represent one of the most serious, yet overlooked, health issues facing our nation.

Under the "Clear Vision, Bright Future" Initiative, Wisconsin optometrists have partnered with parents, school district administrators, school nurses and other health providers to encourage students to receive the eye health and vision care they need. This Initiative provides the opportunity not only to enhance the academic future of your child, but also to provide a strong foundation for those who may be at risk for visual learning problems.

Parents & Teachers - Please do not assume that a child has healthy eyes and no problems seeing in school. That assumption could risk the child's future eye health and school achievement. Have their eyes examined.

**Tips for parents scheduling comprehensive eye exams for their children:**

1. Schedule the exam early in the day, at least 3-4 months before school starts
2. Let your child know that there won't be any shots involved
3. Make a game of it; practice looking at pictures and making it fun

**Wisconsin Law**

A current Wisconsin law, Statute Chapter 118.135 states: Each school board shall request each pupil entering kindergarten to provide evidence that the pupil has had his or her eyes examined by an optometrist or evaluated by a physician.

**Financial Assistance for Eye Exams**

Many children in Wisconsin do not have insurance coverage for eye examinations. Member doctors of the Wisconsin Optometric Association (WOA) provide free eye examinations for children who do not have insurance and who cannot afford such care.

***Please contact the WOA's VISION USA Program at (877) 435-2020 to request an application form or for more information regarding this special program.***

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.

**DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
F-40335 (Rev. 07/08)

**STATE OF WISCONSIN**

# PRESCHOOL ORAL HEALTH PRELIMINARY EXAM AND PREVENTION SERVICES

Participation is voluntary, information collected on this form will be used for tracking treatment, and services provided to the patient and will be used only for this purpose. See instructions below.

| **Date of Preliminary Examination (mm/dd/yyyy)** | **Site** | **Initials - Examiner** |
|---|---|---|
| | | |

**PARTICIPATION INFORMATION**

| **Identification Number** | **Birth Date (mm/dd/yyyy)** | **Age** |
|---|---|---|
| | | |

**Gender**
1=Male
2= Female

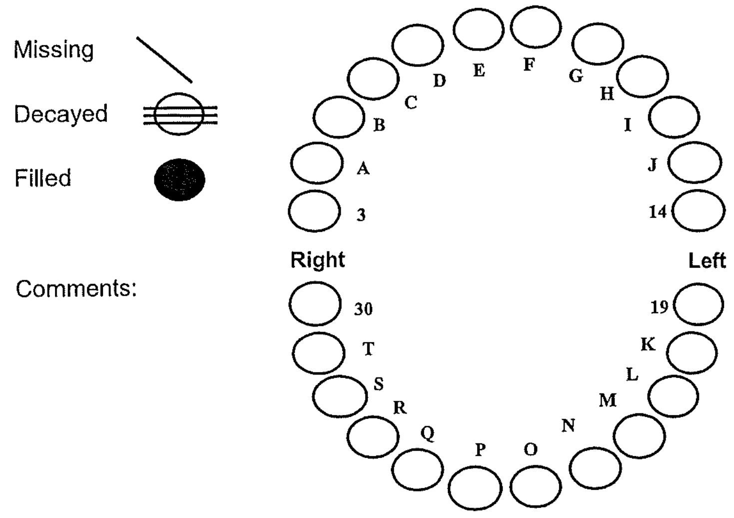
**Race and Ethnicity**
1=White
2=African-American
3=Hispanic
4=Asian
5= American Indian/Alaska Native
6=Native Hawaiian/Pacific Islander
7=Multi-racial
9=Unknown

**Untreated Caries**
0=No untreated cavities
1=Untreated cavities

**Caries Experience**
0=No caries experience
1=Caries experience

**Early Childhood Caries**
0=No ECC
1=ECC present

**Treatment Urgency**
0=No obvious problem
1=Early dental care
2=Urgent care




**Caries Risk Assessment-**check all that -apply-one or more indicates risk

| **Clinical Conditions** | |
|---|---|
| Untreated or treated caries | |
| Enamel demineralization (white spots) | |
| Gingivitis or visible plaque | |
| Wearing dental or orthodontic appliances | |
| Poorly formed enamel, deep pits | |
| Radiographic enamel caries | |
| **Environmental Characteristics** | |
| Suboptimal systemic fluoride exposure | |
| Suboptimal topical fluoride exposure | |
| Frequent consumption of cariogenic foods/ bev. | |
| Irregular or no usual source of dental care | |
| Low income | |
| Special health care needs | |
| Active caries present in the mother | |
| **General Health Conditions** | |
| Special health care needs | |
| Conditions impairing saliva composition/flow | |

| | No obvious problem | Refer 'R' | COMMENTS |
|---|---|---|---|
| **Head and Neck** | | | |
| **Lymph Nodes** | | | |
| **Pharynx** | | | |
| **Tonsils** | | | |
| **Soft Palate** | | | |
| **Hard Palate** | | | |
| **Floor of Mouth** | | | |
| **Lips** | | | |
| **Skin** | | | |
| **TMJ** | | | |
| **Tongue** | | | |
| **Vestibules** | | | |
| **Buccal Mucosa** | | | |

**Community Water Fluoridation Status**
0=No
1=Yes

**Dietary Fluoride Supplementation Status**
0=No, community or well is not fluoridated, not aware of fluoride level*
☐ *Recommend water testing to determine fluoride level
1=Yes, currently uses dietary fluoride supplements
2=NA, community water or well has optimal fluoride level

**Special Health Care Needs**
0=No
1=Yes

**Fluoride Varnish Application Indicated**
0=No
1=Yes
☐ Documented caries risk
☐ Has no contraindications to fluoride varnish (allergy, stomatitis)
☐ Documented parental permission

**Additional Comments:**

**Fluoride Varnish Application Schedule -**.25ml (preschool)
1. Application Date ______Provider Initials_________
2. Application Date ______Provider Initials_________
3. Application Date ______Provider Initials_________

☐ **Referral services complete - Date_____ Initials_______**

**SIGNATURE** – Dental Professional

# SCHOOL DISTRICT OF BRUCE

## Authorization for Medication Administration

## Non-Prescription Medication

Student Name: ________________________________ Date of Birth: ________________

Grade: ______ Teacher (if in elementary school): ________________________________

### Medication Information & Instructions

**Medication Name:** ________________________________________________

☐Tablet/Capsule ☐Liquid ☐Other________________________________

**Dose & Frequency:**________________________________________________

________________________________________________________________

☐ Use throughout school year 20____- 20____ **OR** ☐ Start date________ End date ________

**Reason for medication:** ________________________________________________

### Parent/Guardian Signature

I understand the following:

- Medication must be in the original container with labels and instructions.
- Medication must be age appropriate for the student and not expired.
- Medication must be administered according to the manufacturer's instructions.
- Unused medication must be picked up from school at the end of the school year or it will be disposed of.
- New permission forms must be completed each school year and if there are changes in the medication or dose.

School personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the school district, its employees or persons who are acting on this request, harmless in any and all claims arising from the administration of this medication/treatment at school and school events.

| ______________________________ | ______________________ | ______________ |
|---|---|---|
| Parent/Guardian Signature | Relationship to student | Date |

# SCHOOL DISTRICT OF BRUCE

## Student Health Information

Student Name:______________________________ Date of Birth:__________

### Health History and Health Information

☐ Student does **NOT** have any medical conditions or health concerns

Student has the following medical conditions or health concerns

- ☐ ADHD
- ☐ Autism Spectrum Disorder
- ☐ Asthma Inhaler at school? ☐Yes ☐No
- ☐ Cardiac (heart) Conditions Name of Condition:______________________________
- ☐ Diabetes ☐Type I ☐Type II
- ☐ Migraines/Headaches
- ☐ Seizures (Epilepsy) Type of Seizures:______________________________
  Emergency Seizure Medication:______________________________
- ☐ Allergies (bees, foods, etc.) List Allergies:______________________________
  Does student have an EpiPen? ☐Yes ☐No
- ☐ Other serious medical conditions:______________________________

______________________________________________________________________

### Medication

Is student taking any prescription or non-prescription medication daily or frequently? ☐Yes ☐No
Name and dose of medications:______________________________

______________________________________________________________________

Will student need to take medication at school? ☐Yes ☐No (If yes complete authorization forms)

### Additional information about student health, above medical conditions and treatment:

______________________________________________________________________

______________________________________________________________________

Student's Medical Provider and Clinic: ______________________________

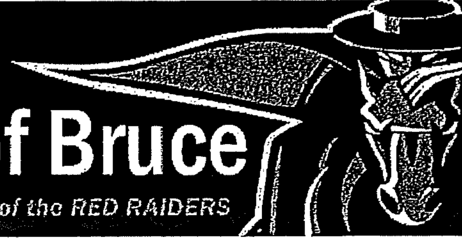
I understand the information I have provided regarding the student's health and medical conditions will be available to school staff in attempt to maintain, manage or treat the condition. I understand that I must inform the school nurse and administrative staff of any changes in the student's health and update the necessary forms.

Parent/Guardian Signature:______________________________ Date:______________

104 W. Washington Ave.
Bruce, WI 54819
715-868-2585

# School District of Bruce

*HOME of the RED RAIDERS*



February 6, 2023

Dear Parents/Guardians:

The Wisconsin Department of Health Services has announced updates to the immunizations required for children in schools and child care settings. Below is a summary of that information. These changes will go into effect beginning the 2023-2024 school year. The changes include updated requirements related to meningitis and pertussis (whooping cough) immunizations, and that past chickenpox infection must be documented by a qualified medical professional. Parent reported cases of chickenpox will no longer be accepted.

**DHS Announces Immunization Updates for Children in Child Care Centers and Schools**

Beginning the 2023-2024 school year, the following minimum immunization requirements must be met, or a waiver submitted to school:

**For entry to kindergarten through 6th grades students need:**

- 4 doses of DTaP/DTP/DT/TD
- 4 doses of polio vaccine
- 3 doses of hepatitis B
- 2 doses of MMR
- 2 doses of varicella (chickenpox)*
  *Exceptions to the varicella vaccine requirement will be allowed in schools only if the child's case has been confirmed by a qualified health care provider. **Parent reported chickenpox cases will no longer be accepted.** If your child had chickenpox in the past, take the updated Student Immunization Record to your qualified health care provider for signature. This record can be found on our school website or at https://dhs.wisconsin.gov/forms/f0/f04020l.pdf

**For entry to 7th - 11th grades students need the above immunizations and:**

- 1 Tdap (changed from a 6th grade to 7th grade requirement)
- 1 MenACWY containing vaccine (Meningococcal serogroup ACWY)

**For entry to 12th grade students need the above immunizations and:**

- 1 MenACWY containing booster (Meningococcal serogroup ACWY)*
  *A second dose is not required for students who received their first dose at age 16 or older.

Students must be up to date on all vaccines listed for previous grades. Waivers for health, religious, or personal conviction reasons can be submitted by completing the waiver section on the Student Immunization Record. If immunizing your student, we encourage you to make appointments as soon as your child is due for a vaccine or in early summer to avoid the late summer rush at clinics. For additional information about these changes you can also visit the Wisconsin Department of Health Services website at https://dhs.wisconsin.gov/immunization/update.htm.

Respectfully,

Amanda Weinert, RN

Amanda Weinert, RN
School Nurse