Altoona Elementary

Learning Today, Leading Tomorrow

Dear Parents of Incoming 5 year old Kindergarten students,

The 2017 - 2018 school year seems far away, yet preparations have already begun for welcoming your child to the new **Altoona Elementary School**. It is very important for our planning process to get an accurate count of the children who will be attending our five year old kindergarten program.

Since your child is currently enrolled in our 4 year old kindergarten program, we **do not** need another completed enrollment form. **To confirm your child will be attending the five year old kindergarten at Altoona Elementary, please call the elementary office no later than Friday, March 17, 2017 indicating if your child will or will not be attending this fall.** You may also email Lisa Boss at lboss@altoona.k12.wi.us.

We will be holding a Kindergarten Orientation at a later date in August. Please watch for your invitation in the mail.

The enclosed health packet forms need to be completed and returned to the elementary office on or before September 7th.

Starting kindergarten is always an exciting. We look forward to a wonderful beginning. Please contact us at 839-6050 if you have any questions.

Sincerely,

Joann Walker

Principal

JW/lb

Enclosure: Health packet

Important Date to Remember

March 17th – Call 715-839-6050 by this date indicating if your child will be attending 5 year old kindergarten at Altoona Elementary.

Altoona Elementary School
157 Bartlett Ave. • Altoona, WI 54720 • (715)839-6050 • Fax (715)839-6166

Altoona School District
1903 Bartlett Ave Altoona, WI 54720
School Health Service

Critical Health Information Form

Dear Parents/Guardians:

We are asking you to provide us with current health information on your child in an effort to identify students with **Critical Health** needs. The information we are requesting should include any life threatening health problems or serious medical conditions or mental health concerns. Please review and complete the information requested.

Student Name _____ School _____ Grade _____

_____ My child does **NOT** have any health problems.

_____ My child has one or more of the following health problems. (Please check all that apply.):

_____ **Diabetes**
_____ **Seizures** (Epilepsy) Medication used:_____
Medication administered at school? ____ Yes____ No
_____ **Cardiac conditions** Specify Limitations:_____
_____ **Asthma** Medication(s) used: _____Inhaler at School? _____Yes _____No
Where is the inhaler kept?____ Locker____ Backpack____ School Office _____Other
_____ **Allergies, Life threatening** (for example bees, foods, etc.) Specify: _____
Specify care needed:_____
Does your child carry an Epi-pen?____Yes_____No
Does your child need help administering the injection? ____Yes____No
Where is the Epi-pen kept?____Locker_____Backpack____School Office____Other
_____ **Other physical health conditions**, Specify: _____
Specify care needed:_____
_____ **Other mental health concerns**,_____Yes_____No
(This information will be followed up on an individual basis for reasons of confidentiality)
Reminder: A medication form is required if your child needs to take medications (prescription and over-the-counter) at school.
Medication taken:_____

Comments:_____

If your child has a serious health concern, he/she should wear a medic-alert bracelet.
You can get more information by calling 800-432-5378.

Please notify the school nurse if there are any changes in your child's health condition by calling Anita E-B Schubring, RN at 839-6031 ext. 246.

I understand that the information I have given regarding my child's health condition will be available to school staff in an effort to provide emergency care should the need arise. I will notify the school in writing if my child's health condition changes.

Parent/Guardian signature: _____ Date: _____

Please return this form to the school office. Thank you.
This form will be completed by parents for newly enrolled students and for grades 4K, 5K, 3, 5, 7, 9 & 11

Altoona School District
1903 Bartlett Ave Altoona, WI 54720
School Health Service

Dental Referral Form

School_____Grade_____Date_____

Name_____ Date of Birth_____

To the Parents:

Our School has a health program that is designed to improve, protect, and promote the health of each student. As a part of this health program we urge you to take your child to the dentist of your choice at least once per year for a dental examination and for whatever treatment may be necessary.

When the examination has been completed, return this form to school.

To the Dentist:

Check the following statements before signing this card:
( ) No dental work necessary.
( ) All immediate dental work has been completed.
( ) Necessary dental work in progress.

Date_____Dentist_____

Altoona School District
1903 Bartlett Ave Altoona, WI 54720
School Health Service

Dear Parent(s) /Guardians:

Altoona Elementary School, in cooperation with the Eau Claire City-County Board of Health, is offering elementary students a fluoride mouth-rinsing program to prevent dental decay. This simple method of applying fluoride has been demonstrated to be safe and effective in controlling tooth decay. Participants will rinse their mouths in school with a 0.2% neutral sodium fluoride solution for one minute once each week under supervision.

This project is very important to the oral health of your child. Participation is entirely voluntary and without cost to you. We encourage you to allow your child to participate in this valuable health project. This preventive program, however, should not take the place of regular dental care by your dentist or proper home care. Please return the completed form without delay to your child's teacher.

If you have questions regarding this project, please call Anita Schubring RN, School Nurse, at 715-839-6031 ext 475 or the Eau Claire City-County Health Department, 715-839-4718.

Sincerely,
Joann Walker, Principal
Altoona Elementary School

Sincerely,
Elizabeth Giese, Director
Eau Claire City-County Health Dept.

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______ I wish my child to participate in the fluoride mouth rinse program.

______ I do not wish my child to participate in the fluoride mouth rinse program.

Name of Child ____ Age ______
(last) (first) (initial)

Date of Birth ____________________________________ Sex _______ Grade _____
(month) (day) (year)

Name of School ________Altoona Elementary______ Teacher ___________________

Signature of Parent or Guardian ____

Altoona Elementary

Learning Today, Leading Tomorrow

Dear Parent:

Please be aware that one dose of DTaP vaccine is required after the 4th birthday. For children who are "up to date" with their preschool DTaP series this will be final (5th) dose that is recommended to ensure prolonged protection, primarily against pertussis also known as whooping cough. For children who are not "up to date" this dose may be the 3rd or 4th in the series and no further doses are required. Because of a 4-day grace period, DTaP vaccine received 4 days or less before the 4th birthday is also acceptable.

The date (month, day, and year) of each immunization must be entered on the Student Immunization Record that is available from your child's school and should be submitted to the school your child will attend.

Waivers are available for religious, health, 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.

You are encouraged to have your child immunized well in advance of school opening to avoid the late summer rush at immunization clinics. For immunizations, contact your doctor, clinic, HMO or nearest public health department

Beginning October 1, 2012, local health departments will no longer be able to administer state supplied vaccine to children that have private insurance which includes coverage for immunizations. You are encouraged to check your health insurance policy to determine if it covers immunizations and if so, you should seek those services from your physician or clinic.

You may view your child's immunization record from your computer on the Wisconsin Immunization Registry (WIR). The WIR is a secure computerized data system that tracks immunizations given to people. The internet address is http://dhfsWIR.org. To obtain the dates of your child's immunizations, type in your child's name, social security or Medicaid number. In order to access your child's record their social security number must be in the system. If it is not, contact your medical provider and ask that the number be put into the WIR so that you can access your child's immunization record. Address information about your child is not provided.

If you would like further information on immunization, please see the following websites: http://www.cdc.gov/vaccines/, http://www.immunize.org/ and http://dhs.wisconsin.gov/immunization/index.htm

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DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 4020L (Rev. 02/08)

STATE OF WISCONSIN
252.04 and 120.12 (16) Wis. Stats.

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

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. 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:					

*Hib vaccine is only required for children in licensed day care centers. Do not report the dates your child received Hib vaccine on this form.

Has your child had Varicella (chickenpox) disease? Check the appropriate box And provide the year if known:
☐ YES _____ year (Vaccine not required)
☐ 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 INCOMPLETEY 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