DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 07/2015)

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, 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:
☐ 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 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** 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. 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

ARCHDIOCESE OF MILWAUKEE

Form
5140.2 (a)

Parent(s)/Guardian Medication Authorization Form
Nonprescription Medication

Student's Name: _____ Date of birth: _____

School: _____ Grade: _____

Diagnosis: _____

As the parent and guardian of the above mentioned student, I give the school permission to administer the following medication(s) to my child for the diagnosis/reason listed above:

Medication Name	Dosage: mg, cc, ml, etc	Route: How it is to be given	Frequency: How often	Start Date	Stop Date	Side Effects
1.						
2.						
3.						

As the parent or guardian of the above mentioned student, I will keep the school aware of any changes in medication(s) profile or health concern of my child.

As a part of the Wisconsin Statute Chapter 118.29, schools are required to have permission from a parent/guardian to administer nonprescription medications at school. As part of this authorization form, school employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

All medications must be in the original container listing the recommended therapeutic dosage. Administration of a dosage other than the recommended therapeutic dose may be given only if the written request to do so is also accompanied by the written approval of the child's medical provider.

Parent(s) Guardian Signature: _____ Date: _____

ARCHDIOCESE OF MILWAUKEE

Form
5140.2(b)

Medical Provider Authorization Form
Prescription Medication

Student's Name: _____ Date of birth: _____

School: _____ Grade: _____

Diagnosis: _____

Daily Medication

Medication	Dosage	Route	Frequency	Start Date	Stop Date	Side Effects
1.						
2.						

As Needed or PRN Medication

Medication	Dosage	Route	Frequency	Start Date	Stop Date	Side Effects
1.						
2.						

Medical Provider Consent

I authorize the school to the give the above medication(s) to this student.

Asthma Inhalers and Epi-Pens Only: This student and his/her parents have been instructed in self-administration and the student may carry an inhaler or Epi-Pen and self administer at school. Yes_____ No_____

Print Medical Provider Name: _____ Phone _____

Medical Provider Signature: _____ Date: _____

Parent Consent

I give the school permission to administer the above medications as directed by the medical provider.
Inhaler/Epi-Pen Only: My child may _____ or may not _____ carry and self administer.

Parent/Guardian Signature: _____ Date: _____

As part of the authorization form, school personnel may contact the medical provider and parent with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above.

Form
5140.2 (c)

Allergy Action Plan

Student Name: _____ Birth Date: _____
School: _____ Grade: _____ Teacher: _____

Place Student Photo Here

ALLERGIC TO THESE ALLERGENS: _____

☐ **Has Asthma** (increases risk for severe reaction)

☐ **Severe Allergy previously/suspected—Immediately give epinephrine & call 911– Start with Steps 2 & 3**

☐ **Mild Allergy** – Itching, rash, hives – **Give antihistamine, call school nurse and parent. Start with Step 1**

► STEP 1: IDENTIFICATION OF SYMPTOMS* ◄

* **Send for immediate adult assistance**

Symptoms:		**Type of Medication to Give:** (Determined by physician authorizing treatment)
➢ If exposed to allergen, or allergen ingested, but ***no symptoms***		☐ **Epinephrine** ☐ **Antihistamine**
➢ **Mouth** –	Itching, tingling, or swelling of lips, tongue, mouth	☐ **Epinephrine** ☐ **Antihistamine**
➢ **Skin** –	Hives, itchy rash, swelling of the face or extremities	☐ **Epinephrine** ☐ **Antihistamine**
➢ **Gut** –	Nausea, abdominal cramps, vomiting, diarrhea	☐ **Epinephrine** ☐ **Antihistamine**
➢ **Throat** –	Tightening of throat, hoarseness, hacking cough	☐ **Epinephrine** ☐ **Antihistamine**
➢ **Lung**** –	Shortness of breath, repetitive coughing, wheezing	☐ **Epinephrine: Call 911**
➢ **Heart**** –	Faint, pale, blueness around mouth or nail beds, weak pulse, low B/P.	☐ **Epinephrine: Call 911**
➢ **Other**** –	_____	☐ **Epinephrine: Call 911**
➢ If reaction is progressing (several of the above areas affected) give		☐ **Epinephrine: Call 911**

** **Potentially life-threatening.** – Note: The severity of symptoms can quickly change.

► STEP 2: GIVE MEDICATIONS ◄

Epinephrine: inject intramuscularly (check one) ☐ EpiPen® ☐ EpiPen Jr®

- **If Epinephrine is given, paramedics must be called! PROCEED TO STEP 3 BELOW.**

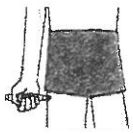
Antihistamine/other: give _____ *(Medication name & amount)* **by** _____ *(route/method)*

- **Notify** parents and school nurse • **Observe** for increasing severity of symptoms • **Call 911** as needed

IMPORTANT: Do NOT depend on asthma inhalers and/or antihistamines to replace epinephrine in a severe reaction.

EpiPen Directions:

a. Pull off the GRAY Safety Cap
b. Place BLACK TIP near OUTER-UPPER THIGH
c. Swing and jab firmly until hearing or feeling a click
d. Hold EpiPen in place **10 SECONDS**, remove, massage area
e. Dispose of in red sharps container or give to paramedics



➢ The EpiPen can be injected through clothing.
➢ The individual may feel his/her heart pounding.
• This is a normal reaction to the medication.

► STEP 3: EMERGENCY CALLS ◄

1. **CALL 911** – *Seek emergency care.* State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Parents or Emergency Contacts

Parent completes Parent and Emergency Contact Names and Information below:

Parents/Emergency Contact *Names:*	*Relationship:*	*Phone Number(s):*
a. _____	1.) _____	2.) ( ) _____ ( ) _____
b. _____	1.) _____	2.) ( ) _____ ( ) _____

Parent/Guardian Signature _____ Date _____
(Required)

Physician completes form through Step 2

Physician Name (Printed) _____ Phone Number: ( ) _____

Physician Signature _____ Date: _____
(Required)

This form must be renewed annually or with any change in medication.
The *Prescription Medication Authorization Form* must be completed in addition to this *Allergy Action Plan*