

**WELCOME TO
VIROQUA AREA SCHOOLS**



**New Student Information
Packet & Forms**

Child's Legal Name _____
 Last First Full Middle

Birthdate_____ Grade_____ Birthplace _____ Gender___M___F

_____ Native Hawaiian or Other Pacific Islander

If no, approved for Open Enrollment? ☐Yes/☐No

Is your child currently expelled from a public school? ☐ Yes/☐ No If yes, name of school _____

PAST PRESENT

Phone Number

(If different address from Parent/Guardian 1 - list below - Should School Reports/information also be mailed to this Parent/Guardian Yes/No

Phone Number

- Please see other side*

Please explain any other circumstances related to custody. Please provide any pertinent court documents related to custody issues and situations. List if there are restrictions of Parent/Grandparent to visit/pickup (you must provide a court document). _____

Is the student receiving any type of medical treatment and/or currently taking medication? Please explain.

CIRCLE if the child has any of the following health conditions/difficulties that the school should be aware of:

*Hearing *Vision *Allergies *Asthma *Seizures *Heart *Diabetes *Attention Deficit
*Other _____

Please describe the condition and include any procedures/accommodations that need to be followed at school related to this condition: _____

OTHER CHILDREN (Age 21 and under and living at home)

Name	Birthdate	Grade	School
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Office Use Only

Date Enrolled _____ Grade _____ Locker: Yes/No Records Request: Yes/No

Forms Received: ☐Emergency ☐Parent/Student ☐Signature ☐Fees ☐Family Access



Wisconsin Home Language Survey

FOR STAFF COMPLETION TO BE COMPLETED FOR ALL NEW STUDENTS			
ESL File Opened <input type="checkbox"/> Yes <input type="checkbox"/> No	ESL Test Date	Today's Date	Test
ESL Evaluator		ESL Level	Placement

PARENT/GUARDIAN HOME LANGUAGE SURVEY	
Student's Name	Grade
Relationship of Person Completing Survey <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other <i>Specify</i>	

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

	English	Other	Other Language(s)
1. What language did the child learn when she or he first began to talk?	<input type="checkbox"/>	<input type="checkbox"/>	
2. What language does the family speak at home most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	
3. What language does the parent(s) speak to her/his child most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	
4. What language does the child speak to her/his parent(s) most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	
5. What language does the child hear and understand in the home?	<input type="checkbox"/>	<input type="checkbox"/>	
6. What language does the child speak to her/his brothers/sisters most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	
7. What language does the child speak to her/his friends most of the time?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Can an adult family member or extended family member speak English?	<input type="checkbox"/>	<input type="checkbox"/>	
Can they read English?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Do the parents/guardians request oral and/or written communication from the school to be in English?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Written
If no, in what language			

SIGNATURE	
Signature of Person Completing Survey	Date Signed

Adapted from: *Sample Survey, Institute for Cultural Pluralism*, Lau General Assistance Center, San Diego State University, San Diego, CA 921882 [sic], 1976

VIROQUA AREA SCHOOLS

Emergency Contact Form

2023-2024

This information is updated yearly for the safety of your child.

Student: _____ Date of Birth: _____ Grade/Class: _____

Student lives with: (Circle) Both Parents Father Mother Grandparents Guardian

Other: _____

FAMILY 1

Home Address _____		Primary Phone #: _____
Guardian 1: _____	Relationship to Student: _____	Secondary Phone: _____
Email Address: _____	Employer: _____	Work Phone: _____
Guardian 2: _____	Relationship to Student: _____	Secondary Phone: _____
Email Address: _____	Employer: _____	Work Phone: _____

FAMILY 2

Home Address _____		Primary Phone #: _____
Guardian 1: _____	Relationship to Student: _____	Secondary Phone: _____
Email Address: _____	Employer: _____	Work Phone: _____
Guardian 2: _____	Relationship to Student: _____	Secondary Phone: _____
Email Address: _____	Employer: _____	Work Phone: _____

Is either parent or guardian on active duty in the military?	Yes	No
Is either parent or guardian a traditional member of the Guard or Reserve?	Yes	No
Is either parent or guardian a member of the Active Guard/Reserve (AGR) under Title 10 or full time National Guard under Title 32?	Yes	No
Is this student considered a Homeless Unaccompanied Youth?	Yes	No
Does this student have a Homeless Primary Nighttime Residence?	Yes	No

Siblings attending Viroqua Area Schools (Name & Grade): _____

TWO LOCAL PEOPLE TO CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

(Please provide contacts from different households)

1.) Name: _____ Relationship: _____
Phone: _____ Alternative Phone(s): _____

2.) Name: _____ Relationship: _____
Phone: _____ Alternative Phone(s): _____

In case of an Emergency school CLOSING, my child should: _____

Signature of Parent/Guardian: _____ Date: _____

VAS Annual Health Information Update 2023-2024

Student Name: _____ D.O.B.: _____ Grade: _____

Dear Parent/Guardian:

Please complete the Annual Health Information Update for your child. Include any life threatening health problems or serious medical conditions that could pose a risk for your child during the day or at extra-curricular activities. Return this form to your child's school for review by the school nurse. You may be asked to complete additional forms and emergency action plans if needed. **If your child requires medication during the school day for any of the below conditions, please complete a medication form per school policy.**

_____ **My child does NOT have any known health conditions or concerns**

My child has the following health conditions/concerns:

ALLERGIES (*Fill out Allergy Action Plan*)

LIFE THREATENING Allergy: _____

Type of reaction/Treatment: _____

Epi-Pen given to school YES/NO (circle)

Epi-Pen carried in backpack YES/NO (circle)

Bee Sting Allergy: Reaction/Treatment: _____

Epi-Pen given to school YES/NO (circle)

Epi-Pen carried in backpack YES/NO (circle)

Food Allergy: _____

Type of reaction/Treatment: _____

Other Allergies: _____

Type of reaction/Treatment: _____

Food Intolerance: _____

Type of reaction/Treatment: _____

Asthma: Triggers: _____

(*Fill out Asthma Action Plan*)

Inhaler given to school YES NO (circle)

Inhaler in backpack/carried by student YES NO (circle)

Diabetes: Type: _____

On Insulin: YES/NO (circle) Insulin Type: Syringe/Pump/Pen (circle)

(*Fill out Diabetes Action Plan*)

Meter/emergency supplies given to school YES NO (circle)

Meter/emergency supplies carried by student YES NO (circle)

Seizures: Type/Description: _____

(*Fill out Seizure Action Plan*)

Treatment: _____

On Medication YES/NO (circle)

Emergency Medication at School YES/NO (Circle)

ADD / ADHD (circle) _____

On Medication YES/NO (circle)

Anxiety / Depression (circle) _____

On Medication YES/NO (circle)

Other Health Conditions or Concerns: _____

Name of Guardian Completing form: _____

Signature: _____ Date: _____

Office Use Only

Action Plan Needed? Y/N

Action Plan Received? Y/N

VIROQUA SCHOOL DISTRICT

STANDING ORDER FOR STOCK MEDICATION FORM

Scenic Bluffs School Health Services Standing Orders

No Child shall receive a medication or medication product without proper consent. Over-the-counter medications require parent authorization and can only be administered per manufacturer dosing instructions once parent approval is obtained.

Student Name:	Date of Birth:	School:	Grade:
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Note: For Medication brought from home, please fill out the "Prescription and Over-the-Counter Medication Form"
 (All prescription medication or medication to be given other than the package directions must be accompanied by a Medication Form signed by the practitioner and guardian.)

SCHOOL STOCK MEDICATIONS: I authorize the school to administer the following over-the-counter medications (brand or generic) based off package age/weight dosing guidelines if needed.
This order is in effect for this school year only. Select all that apply:

ORAL	TOPICAL
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Bug Spray
<input type="checkbox"/> Cough Drop	<input type="checkbox"/> Chapstick/Lip Balm
<input type="checkbox"/> Diphenhydramine/Benadryl	<input type="checkbox"/> Contact Solution
<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Diphenhydramine/Benadryl
<input type="checkbox"/> Tums/Antacids (Age 12+)	<input type="checkbox"/> Eye Drops
	<input type="checkbox"/> Hydrocortisone Cream
	<input type="checkbox"/> Lotion
	<input type="checkbox"/> Pain Relieving Spray
	<input type="checkbox"/> Sunscreen
	<input type="checkbox"/> Triple Antibiotic Ointment
<input type="checkbox"/> NO PERMISSION GIVEN	<input type="checkbox"/> Vaseline

Comments _____

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

Date	Parent/Guardian Signature	Phone #
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WELCOME TO VIROQUA AREA SCHOOLS



Health Information Packet

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.

**Table 144.03-A
Required Immunizations for the 2023-2024 School Year**

Age/Grade	Required Immunizations (Number of Doses)							
5 months through 15 months	2 DTP/DTaP/DT		2 Polio			2 Hep B	2 Hib	2 PCV
16 months through 23 months	3 DTP/DTaP/DT		2 Polio	1 MMR		2 Hep B	3 Hib	3 PCV
2 years through 4 years	4 DTP/DTaP/DT		3 Polio	1 MMR	1 Var	3 Hep B	3 Hib	3 PCV
Kindergarten through grade 6	4 DTP/DTaP/DT		4 Polio	2 MMR	2 Var	3 Hep B		
Grade 7 through grade 12	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B		

- 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 6, which would normally correspond to the individual's age.
- 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.
- 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.
- 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.
- 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.
- Laboratory evidence of immunity to hepatitis B is also acceptable.
- 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.
- Varicella vaccine is chickenpox vaccine. Students with a reliable history of varicella disease are not required to receive the Varicella vaccine. A parent or guardian may indicate that their student has had chickenpox on the Student Immunization Record form (F-04020L).



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)		Telephone Number	

Step 2 **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, 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 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) <input type="checkbox"/> Tdap <input type="checkbox"/> Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine <i>Vaccine is required only if your child has not had chickenpox disease. See below:</i>					
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)			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) <input type="checkbox"/> Varicella <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> 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

☐ 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

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

Wisconsin Immunization Registry: Information for Parents

Did you know that you have access to your or your child's vaccine records online?

Vaccines, also called shots or immunizations, are given over a person's lifetime to keep everyone healthy. The Wisconsin Immunization Registry, also called WIR, allows patients, parents, and guardians of children to view their vaccine record and keep track of their vaccines.

Why is tracking our vaccine record in WIR important?

Today we move, travel, and change doctors more often than we did in the past. Tracking an updated vaccination record using WIR will save you money, time, and the hassle of making additional vaccine appointments.

Are our vaccine records available to others?

The public does not have access to your records. The records are secure and follow laws that protect patient data.

Can WIR tell me what vaccines are missing?

Yes, WIR uses advances in science and technology to calculate a vaccination schedule. It can tell you what vaccines you need and when you should plan your next vaccine visit at your doctor's office.

I need to have my child's vaccine records for school enrollment. Can WIR help me with this?

Yes, you can view and print the vaccine records for school enrollment by following the steps on the back of this page.

Does my doctor's office use WIR?

Maybe. Not all doctor's offices in Wisconsin use WIR. If you see a doctor who does not use WIR, you can call your doctor's office and request the vaccine record.

I had vaccines that are missing from WIR. How do I correct it?

Provide the proof that you had the vaccine to your doctor's office or local health department and they can enter your vaccine information for you.

If I got a vaccine in another state, will it be in WIR?

Maybe. WIR shares information with Minnesota and Michigan. If you had a Wisconsin address when you got the vaccine in one of those states, WIR may have a record of the vaccine.



Looking for your or your child's vaccine record?

Step 1. Go to <https://www.dhfs.wis.gov>.

Step 2. Near the bottom of the page, in the Public Immunization Record Access section, click on the Public Immunization Record Access link.

Step 3. On the next screen, enter your or your child's first name in the First Name field and last name in the Last Name field.

Step 4. In the Birth Date field, enter the person's birth date using the MM/DD/YYYY format, or use the pop-up calendar by clicking the calendar icon to the right of the field.

Step 5. Enter one of three choices in the next section: social security number, Medicaid ID or health care member ID, or chart number in the appropriate field.

Step 6. Click Search. You will see your or your child's vaccine record and a list of due or upcoming vaccines. Note, if the person cannot be found in WIR, you will get the following message: "No match was found. Please contact your health care provider."

Step 7. Click Print to print out the immunization record, if needed. You can use this as proof of vaccination for child care or school entry, summer camps, or for your place of work.

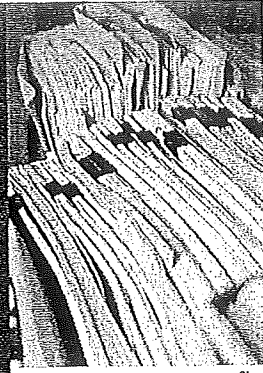
My record is not coming up in WIR, what should I do?

- ▶ If you tried to do a search but the record did not come up, check that all of the information that you entered is spelled correctly.
- ▶ If the search still does not work, call your doctor or local health department to troubleshoot the issue. You can also contact the WIR helpdesk at dhs.wirhelp@dhs.wisconsin.gov for assistance.

Why can't I find the record I am looking for in WIR?

This may have happened for a number of reasons:

- ▶ The vaccine record may not have been recorded in WIR by a doctor's office.
- ▶ The vaccine record is in WIR, but the searchable information (for example, the Social Security Number, date of birth, or chart number) may be missing or wrong.
- ▶ Multiple records may exist for the same person and WIR does not know which one you need.



Viroqua School Nurse

Elementary School Office 608-637-1103

Middle & High School Office 608-637-1509

WHEN TO KEEP YOUR CHILD HOME FROM SCHOOL DUE TO ILLNESS

Students should be kept home from school when they are not feeling well. They need the rest to recover from whatever illness they are suffering from, and this will help prevent the spread of germs/virus to other students.

Please notify the school if your child will be staying home sick and provide the reasoning for it so we can monitor other students for related illnesses.

Attendance Lines - Elementary: 637-1101, Middle School: 637-3171, High School: 637-1600

Please keep your child home if they meet any of the following criteria:

FEVER: Do not send your child to school if they are running an oral temperature of 100.0°F or higher. Your child should be fever free for 24 hours without the use of fever reducing medications before returning to school. Any child with a temperature over 100.0°F will be sent home per school policy.

NAUSEA, VOMITING & DIARRHEA: Do not send your child to school if they threw up or had diarrhea during the night. Keep them home and let them rest for 24 hours before returning to school. Students who have episodes of vomiting or diarrhea at school will be sent home.

COUGH: A cough may be a sign of many different illnesses. If the cough lasts for more than several days, please contact your healthcare provider to determine if treatment or follow-up care is needed. If you send cough drops or any other medications for a cough, a Medication Sheet must be filled out and signed before they can be administered at school. Medications need to be given to the School Nurse, and cannot be left in lockers, book bags, or classrooms.

CONJUNCTIVITIS: (PINK EYE) Your child MUST remain home for 24 hours after medical treatment has been started.

RASH/SKIN PROBLEMS: Many rashes like Fifth disease, Impetigo, Hand Foot and Mouth, Scabies, Staph or Strep skin infections are very contagious. Please keep your child home for 24 hours after treatment has been started or until your physician states it is safe for them to return to school.

RINGWORM: Students should be kept home until treatment is started or infected areas MUST be covered while at school – if a child is unable to keep them covered, they will be asked to go home if no treatment has been initiated.

STREP THROAT: Your child MUST remain home for 24 hours after medical treatment has been started.

CHICKENPOX: Your child will be excluded from school until all vesicles have crusted over which will be about 5-7 days.

LICE: If live lice or nits are found, students will be sent home. They need to be treated prior to returning to school and they must be checked by staff in the Health Office to verify that they have been treated in order for them to return to school.