VERONA AREA SCHOOL DISTRICT Medical Evaluation

To the Health Care Provider: Please complete and sign.

_____ _____ ____/_ __ ___ has had a complete history and physical exam on _____.
Student's Name Birth Date Month/Day/Year

Screenings: (Note) these are recommended under Wisconsin State Law.

Vision Screen Right Left
With Glasses 20/ 20/
Without Glasses 20/ 20/
☐ Referral made

Auditory Screen Type:_____
Right: Pass ☐ Fail ☐
Left: Pass ☐ Fail ☐
☐ Referral Made

IMMUNIZATIONS: (Note) these are required under Wisconsin State Law.

☐ Wisconsin Immunization Registry Record Attached

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*	*	
IPV/OPV	*	*	*	*		
HEP B	*	*	*			
MMR	*	*		Had disease: (date)		
VARICELLA	*	*		Had disease: (date)		

* = required immunizations

EXEMPTION

☐ Personal Waiver ☐Medical Waiver ☐ Religious Waiver
Parent/Guardian Signature _____Date_____
Physician Signature for Medical Waiver _____ Date_____

This student has the following problems which may adversely affect his/her educational experience:
☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical ☐ Emotional/Social ☐ Behavior
☐ This student has a health condition which may require emergency action at school, e.g. seizure, allergies. Specify below. Attach additional sheets if necessary.

_____
_____
_____
_____

☐ This student is on medication. (Prescription medications require a Doctor's Signature- see back of this form)
☐ This student may participate fully in the school program, including physical education activities.
☐ This student may participate in the school program and physical education with the following restrictions/adaptations:

_____
_____
_____

☐ I would like to discuss information in this report with the school nurse.

_____ _____ _____
Signature of Health Care Provider Name (please print or type) Date

Verona Area School District

Physician Order for Medication

Please administer the following medication(s) or perform the following procedure(s):

Name of Student	School
Diagnosis	Date of Birth
Name of Physician ordering medication or procedure	Phone number of physician
	Fax number of physician

Medications Medicine/Procedure	Route	Dose	Frequency	Duration	Potential side effects that should be reported
				From: To:	
				From: To:	
				From: To:	
				From: To:	
				From: To:	

Hospital/Clinic/Office	Phone Number
Address: Street, City, State, Zip	
Physician's Signature	Date
Comments:	

RETURN THIS FORM TO THE SCHOOL NURSE