



Dear Parent:

Congratulations! You have a child entering kindergarten next fall. The La Crosse County Health Department and the State of Wisconsin want all students to be as healthy as possible. The Wisconsin Student Immunization Law requires children starting kindergarten to have the following vaccines:

- **4 DTP** – diphtheria, tetanus, pertussis (whooping cough) One dose must be received on or after the fourth birthday.
- **4 Polio**
- **2 MMR** –Measles, mumps, rubella (German measles) The first dose must be received on or after the first birthday.
- **3 Hepatitis B**
- **2 Varicella** – chicken pox. Chickenpox disease history is also acceptable.

The school will need a record of all the immunizations your child has received. A Student immunization Record will be available from the school for you to fill out.

You are encouraged to have your child immunized as soon as possible after their 4<sup>th</sup> birthday to avoid the late summer rush at immunization clinics. Immunizations are available through your regular clinic or the La Crosse County Health Department. The Health Department has immunization clinics available at the following places and times:

*The La Crosse County Health Department also schedules appointments as needed.  
Call 785-9723.*

We look forward to your child starting school at West Salem Elementary.

Thank you,  
West Salem Elementary School Nurse

**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<br>( ) |             |

**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<br>Mo/Day/Yr | SECOND DOSE<br>Mo/Day/Yr | THIRD DOSE<br>Mo/Day/Yr | FOURTH DOSE<br>Mo/Day/Yr | FIFTH DOSE<br>Mo/Day/Yr |
|--|-------------------------|--------------------------|-------------------------|--------------------------|-------------------------|
| DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)  |                         |                          |                         |                          |                         |
| Adolescent booster (Check appropriate box)<br><input type="checkbox"/> Tdap <input type="checkbox"/> Td  |                         |                          |                         |                          |                         |
| Polio  |                         |                          |                         |                          |                         |
| Hepatitis B  |                         |                          |                         |                          |                         |
| MMR (Measles, Mumps, Rubella)  |                         |                          |                         |                          |                         |
| Varicella (Chickenpox) Vaccine<br>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<br>And provide the year if known:<br><input type="checkbox"/> YES _____ year (Vaccine not required)<br><input type="checkbox"/> 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 INCOMPLETELY 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