

RETURNING STUDENT HEALTH/EMERGENCY RECORD

Student Last Name First Name D.O.B.

In the event of an EMERGENCY accident or illness and parent(s) cannot be reached, I authorize Kohler school personnel to arrange for transportation of the above name child to the following doctor and/or clinic:

Child's Doctor Date of last appt.

Child's Dentist Date of last appt.

In the event of a SERIOUS EMERGENCY I authorize Kohler School to transport to my child to the nearest hospital or medical facility. I agree to assume all costs involved.

I give permission for my child's health information to be shared with appropriate school staff.

Signature of Parent/Guardian Date

Please attach any immunizations received in the past year.

- Yes No
Asthma/Asthma trigger
Diabetes
Seizure Disorder/specify
Heart Disease - specify
Physical Handicaps - specify
Glasses/Contacts (circle if applicable)
Hearing problems? Describe

ALLERGY/MEDICATION INFORMATION

- Food Allergy/Describe Symptoms/Action to be taken
Insect Sting-Describe Symptoms/Action to be taken
Will an Epi-pen Injection be kept at school?

Is your child taking medication? If medication/Epi-Pen will require dispensing during school hours, a Sheboygan County Student Medication Authorization Form with physician signature is required by the state of Wisconsin for each medication. You may access this form from our website and bring the completed form with you to registration.

Please list any medical conditions/surgeries/serious illnesses as well as any special accommodations that may be necessary as result:

IMPORTANT REMINDER: It remains the sole responsibility of the parent to communicate significant health concerns to their child's teachers, coaches and Heidenreiter bus company (467-2651).

Changes in Medical History

SHEBOYGAN COUNTY STUDENT MEDICATION AUTHORIZATION FORM

Dear Parent or Guardian:

Medications should be administered to students by their parents/guardians at home whenever possible. In the event this is not possible, proper written consent must be given to designated school personnel to administer medication.

For Nonprescription Medications:

Parent/Guardian written authorization is required.

For Prescription Medications:

Parent/Guardian written authorization and Practitioner written authorization is required.

No medication will be administered by school personnel or its agents until the consent forms are completed and on file with the school. Medication authorization and administration forms will be kept and stored confidentially as required under Wis. Stat. 118.29(4).

All medication must be in the original container labeled with the student's name, dosage, time, and quantity to be given. All prescription medication must be in the original container labeled from the pharmacy. All medication will be kept in a securely locked cabinet or storage area only accessible to those who have been given the authority to administer medications to students.

Parents are responsible for bringing medication to school and picking up unused medication within 10 days after the medication is discontinued. Students are not allowed to transport their medication from school. School personnel who administer medications to students will have been provided orientation and training. By law, school personnel may not cut tablets. If your child needs to receive half a tablet, have this done at home or by the pharmacy filling the prescription. Current school policy does not allow non-FDA approved drugs (herbal medication) to be administered at school.

Students who self-administer medication still need to have a medication authorization form on file at school. It is recommended that students carry no more than one-week medication supply.

In accordance with the standards of nursing practice, the school nurse may refuse to administer or allow to be administered any medication, which, based on her/his assessment and professional judgement, has the potential to be harmful, dangerous, or inappropriate. In these cases, the school nurse shall notify the parent/guardian and licensed prescriber for the reason for the refusal explained. Under Wis. State 118.29(2)(a)(3), anyone with the authority to administer a non-prescription or prescription drug to a student, excluding nurses, is immune from civil liability unless the act or omission constitutes a high degree of negligence.

Sheboygan County Medication Authorization Form

Note: Each medication requires a separate form

Parent Completes This Section:

Name: _____ Birthdate: _____

School: _____ Grade: _____ Teacher/HR: _____

Medication: _____ Dose: _____

Route/Mode of Administration: _____ Frequency: _____ Duration: _____

(Not to exceed current school year)

Times to be Given: _____ Start Date: _____ Stop Date: _____

Potential Adverse Reactions: _____

If PRN (as needed), state conditions under which school personnel should administer medication (i.e. headache, fever, pain, cough, etc.): _____

Student **may** _____ or **may not** _____ carry and/or self-administer medications at school.

I hereby give permission for personnel designated by the principal or school nurse to give this medication to my child according to the directions stated. I also authorize school personnel designated in medication administered to contact my child's practitioner or me if there is a question regarding medication administration. I agree to notify the school when the drug is to be discontinued and/or the dosage or time changed. I understand that if the medication is resumed, a new Medication Authorization Form is required. I understand that any unused medication will be properly disposed of within 10 days if not claimed after discontinuation of the medication. No medication will be sent home with students. I agree to hold the School District, its employees and agents, excluding health care professionals, who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

X _____

(Parent or Guardian Signature)

Home Phone: _____

Date: _____

Work Phone: _____

Physician Completes if Medication is Prescribed:

I acknowledge by my signature on this document that I will assist and advise designated school personnel with regard to the administration of medication described below, which includes accepting direct communication. I further acknowledge that all instructions should be stated in language of the lay person. I further understand that if the student is allowed to self-administer medication, that proper instruction has been given.

Diagnosis/Reason for Medication: _____

Medication: _____ Dose: _____

Route/Mode of Administration: _____ Frequency: _____ Duration: _____

(Not to exceed current school yr.)

Times to be Given: _____ Start Date: _____ Stop Date: _____

Special Instructions for Administration: _____

Potential Adverse Reactions: _____

(If noted, school personnel should contact parent/guardian/or physician)

Request that school nurse see student in follow-up for: _____

Child **may** _____ or **may not** _____ carry and/or self-administer medications at school.

(Practitioner Signature)

(Phone Number)

(Practitioner Name)

(Date)

(Practitioner Address)

**School District of Kohler
Kohler, WI
Form 2R**

**Board Policy
Student Acceptable Use and Internet
Safety Policy Consent Form**

Student Acceptable Use and Internet Safety Policy Consent Form

Dear Parent or Guardian:

Your son or daughter will soon have access to the school Internet/school network. Online is the Kohler School Policy 7540.03 -Student Acceptable Use and Internet Safety Policy, adopted by the School Board. Please read over the policy and indicate your decision whether to grant permission. Please be sure your child has read the policy and also signs below. Have your son/daughter return this letter to his/her teacher or the district office.

If you have any questions, please contact your student's teacher.

Sincerely,

Board of Education

_____ I give my child permission to use the Internet/Network subject to Policy 7540.03.

_____ I **DO NOT** give my child permission to use the Internet/Network.

Student Name

Grade

Teacher

Parent/Legal Guardian Signature

I have read Policy 7540.03 of the School District of Kohler and agree to abide by the provisions.

I understand that violation of the provisions stated in the policy may result in suspension of INTERNET/NETWORK privileges.

Student Signature/Date

Student(s)/Family Name _____

No Photo Option

From time to time we wish to take photographs/videos of students in normal school settings for use in school district media releases, publications, website, and/or video productions.

I give my permission to include my child(ren) in pictures for any school district media releases, publications (including yearbooks), website, and/or video productions (including holiday music programs).

I do not wish to have my child/child(ren's) picture included in:

- School website
- School district media releases (**newspapers**)
- Publications (**including yearbook**)
- Video productions (**including holiday music programs**)

Family Access

- I have viewed family access and there are no changes.**
- I have viewed family access and the following changes need to be made:**
 - Emergency Contacts _____

 - E-mail _____
 - Phone numbers _____
 - Place of Employment _____

Parent Name(Please Print) _____

Signature of Parent/Guardian _____

KOHLER SCHOOL PHONE DIRECTORY

Kohler School Friends will publish the Kohler School phone directory in September, featuring the following family and student information:

- Parent/guardian names
- Student names and grade in school
- Elementary classroom assignment
- Home address
- Phone Number
- Email address

I give the Kohler School District permission to share this information with Kohler School Friends for the express purpose of compiling and publishing the directory, which will be distributed only to District families and staff.

Student last name (please print): _____

Parent/Guardian Signature: _____

***If you have questions or concerns about the Directory or the publication of your family's information, please contact Lisa Morrissette LLMorrissette@charter.net.

If your child resides in 2 homes during the school year, please provide information for the second household:

Parent/guardian name: _____

Address: _____

Phone number: _____

Email address: _____

Every home will receive 1 free directory. If you would like additional copies, they may be ordered at a cost of \$3.00 per copy. Payment will be collected when directories are delivered.

Number of extra directories requested: _____

**Kohler School District
333 Upper Road
Kohler, WI 53044
920-459-2920
FAX 920-459-2930**

Kohler Public Schools Guidelines

Dear Parents:

You are requested to review the Bylaws and Policies with regards to student policy 5000 on the Kohler School website www.kohlerpublicschools.org. **Please click on the District tab. Bylaws, Policies and Guidelines are on the right hand side.** Please read, review and discuss this policy with your daughter(s) and/or son(s).

Once this information has been discussed with your child, print this page and **complete the bottom and sign the bottom portion of the letter.** *You will need to bring this with you at registration.*

Thank you for your assistance.

Sincerely,

Martin Lexmond
Superintendent/HS Principal

Susan Jaberg
Elementary/Middle School Principal

I have read and reviewed the student policies with my child/children.

Please PRINT name(s) of your child/children

Parent/Guardian Signature

Please PRINT Parent's/Guardian's Name

Date

**Kohler School District
333 Upper Road
Kohler, WI 53044
920-459-2920
FAX 920-459-2930**

Kohler Public Schools Bullying Policy

Dear Parents:

You are requested to review Bullying Policy 5517.01 on the school website. Click on: **District tab. Bylaws, Policies and Guidelines are on the right hand side.** Please read, review and discuss this policy with your daughter(s) and/or son(s).

Once this information has been discussed with your child, print this page and **complete the bottom and sign the bottom portion of the letter.** *You will need to bring this with you at registration.*

Thank you for your assistance.

Sincerely,

Martin Lexmond
Superintendent/HS Principal

Susan Jaberg
Elementary/Middle School Principal

I have read and reviewed the student policies with my child/children.

Please PRINT name(s) of your child/children

Parent/Guardian Signature

Please PRINT Parent's/Guardian's Name

Date