



5K-Grade 5 ★ REGISTRATION FORM ★



A NON-REFUNDABLE BOOK & MATERIAL FEE OF \$20 APPLIES TO ELEMENTARY GRADES 5K-5

Note that this fee is collected when the school year begins – not during Kindergarten registration.

Student Legal Name: AS ON BIRTH DOCUMENT (Last Name) (First Name) (Full Middle Name) (Suffix – Jr. III, etc.)

Gender: Male Female Birth Date:

Place of Birth: (City) (State) (County)

Mother's Name on Birth Document:

Father's Name on Birth Document:

Office Only: Birth document verified by (full name): Document type: Birth Certificate Baptismal Certificate Passport Immigration Certificate

GRADE Entering: If born outside U.S., date first attended a U.S. school:

We will request records from the last school your child attended. Please provide the following:

School last attended (school name):

School location (city, state):

Date last attended at previous school:

Complete ONLY IF you are registering for Kindergarten. We believe early education is important to a child's development. Please help improve your child's educational options by answering the following questions concerning 4K attendance:

- My child attended 4K last year My child did NOT attend 4K 4K was not available in my community where we were living Child care was not available Other:

.....

- Has this student ever attended a Wisconsin Rapids Public School? Yes No If yes, what school? Has this student ever been enrolled in any type of special education program? Yes No If yes, please explain: Is this student currently receiving "English Language Learner" services (ELL, EL, ESL)? Yes No Wisconsin State Statute 120.13 (1) (f) states that no school board is required to enroll a pupil during the term of his or her expulsion from another school district. Has this student ever been expelled from a school or have an abeyance agreement in lieu of expulsion? Yes No If yes, please explain:

If this child qualifies for transportation services, would he/she ride the bus:

Usually; Occasionally; Rarely; or Never Please select one.

\*Your selection above does not affect your child's ability to receive transportation now or in the future.

.....

PLEASE TURN FORM OVER AND COMPLETE BACK SIDE

**RACE:** (Federal regulations require **both questions must be answered, Part I and Part II**)

**Part I: Ethnicity Designation**

**Is the person Hispanic or Latino?** Must choose one.

- Hispanic or Latino *[If selected go to Question I-A]*
- Not Hispanic or Latino *[If no, go to Question Part II]*

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**Optional Question I-A:** If Hispanic or Latino was chosen above, select all that apply from the list below:

- Columbian
- Mexican
- Spaniard/Spanish/Spanish-American
- Unknown
- Ecuadorian
- Puerto Rican
- Other
- Guatemalan
- Salvadoran
- Decline to indicate

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**Part II: Race Designation**

**Select one or more of the following categories that apply to this person:**

- American Indian or Alaska Native *[If selected go to question II-A]*

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**Optional Question II-A:** If chosen, select only one from the list below:

- Bad River Band
- Lac Courte Oreilles
- Oneida Nation (Wisconsin)
- St. Croix
- Other *Please select value form Tribal Affiliation List* \_\_\_\_\_
- Forest County
- Lac du Flambeau
- Red Cliff
- Stockbridge
- Ho-Chunk
- Menominee
- Sokaogon
- Brothertown

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- Asian *[If selected go to question II-B]*

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**Optional Question II-B:** If chosen, select all that apply from the list below:

- Burmese
- Hmong
- Korean
- Unknown
- Chinese
- Indian
- Vietnamese
- Other
- Filipino
- Karen
- Decline to indicate

- 
- Black or African American *[If selected go to question II-C]*

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**Optional Question II-C:** If chosen, select all that apply from the list below:

- African-American
- Liberian
- Decline to indicate
- Other
- Ethiopian-Oromo
- Nigerian
- Unknown
- Ethiopian-Other
- Somali

- 
- Native Hawaiian or Other Pacific Islander

- 
- White
- 

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



510 Peach Street  
 Wisconsin Rapids, WI 54494  
 (715) 424-6700

**WISCONSIN RAPIDS PUBLIC SCHOOLS  
 DISTRICT STUDENT INFORMATION FORM**

Primary Phone: \_\_\_\_\_  
 Last Name /Full First Name/Full Middle Name/Suffix (Jr., III, etc.) \_\_\_\_\_

WRPS School enrolling: \_\_\_\_\_ Student Cell Phone (optional): \_\_\_\_\_

Are you enrolling under:  Boundary Exception  Open Enrollment  Neither – this is student's

Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

**Who has primary/physical custody of student?**  Father/Mother in Same Home Together  Father  Mother  Step Parent  
 Foster Parent  Guardian  50/50 Joint Custody Father/Mother  Other \_\_\_\_\_  
 (Primary custodians listed under Family 1 will be contacted FIRST in cases of emergency or illness.)

Do you have a court ordered custody agreement?  Yes  No  N/A

(If YES, please provide a copy of the most current paperwork.)

**Who does the student live with?** If child lives with BOTH parents at same address, please fill out section 1. If child lives part-time at one residence as the primary placement address, and part-time at another address due to a custody arrangement, please fill out the information in section 1 below for the primary placement address, and section 2 below to indicate the secondary address where the child resides.

Please include your e-mail address on this form – it is very important for communication.

**1 FAMILY 1**

This gray section pertains to the person having primary custody who is completing this form:

Guardian: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

YOUR Address: \_\_\_\_\_

City State Zip

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
 Times Worked: \_\_\_\_\_

Home Phone: \_\_\_\_\_

**Other Adult Contact Person at Above Address:**

NOTE: Only list parents, legal guardians, step-parents, or foster parents. All others should be listed on the back under "Emergency Contacts." (Examples: Adult Siblings, Aunts, Uncles, Grandparents, Friends)

NAME: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

If the above individual is a step-parent, do you grant permission for the school to communicate with and share information with him/her concerning the student whom you are enrolling?  YES  NO

Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
 Times Worked: \_\_\_\_\_

**2 FAMILY 2**

Relationship:  Father  Mother  Step Parent  Foster Parent  Guardian  Other \_\_\_\_\_

Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip

Place of Employment: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_  
 Times Worked: \_\_\_\_\_

Please turn form over to complete back side.

Revised 01/26/2021 jtw

CURRENTLY, where is the **student** living? (**Check one**) *Please note: This is a required question which affects District funding for our Homeless program. Thank you for taking the time to answer this question.*

- WITH parent/guardian in own home or apartment
- WITH friends or family members (without parent/guardian)
- WITH parent/guardian at another family/friend's home due to loss of housing or as a result of economic hardship
- IN shelter (example: Family Center)       IN motel, car, or campsite
- STUDENT on own, in home or apartment       OTHER (please explain) \_\_\_\_\_

Other children from your household attending Wisconsin Rapids Public Schools:

Name : \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name : \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name : \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

### **MIGRANT INFORMATION**

- Have you moved within the preceding thirty-six (36) months for the purpose of finding seasonal or temporary employment directly related to the producing or processing of crops or livestock, dairy farm employment, planting or harvesting trees, or catching shell fish or fish in natural waters?  
 YES       NO

**If yes:** When did you move? \_\_\_\_\_

From where did you move? \_\_\_\_\_

To where did you move? \_\_\_\_\_

- Did any children from birth to twenty-one (21) years of age move with you, or move to join you, related to this work search or employment?       YES       NO
- Are you under twenty-two (22) years of age?       YES       NO
- May local or state education staff visit with you at your home for more information from you about migratory children in your household?  
 YES       NO      Best time of availability: \_\_\_\_\_

### **MILITARY QUESTIONNAIRE**

We are required to ask the following information (please check "yes" or "no" as appropriate):

- 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

**DAYCARE PROVIDER** (if applicable): Does your child attend daycare? Please fill in the information below concerning daycare attendance:

NAME OF DAYCARE PROVIDER(S): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

**EMERGENCY CONTACTS:** List up to four individuals who will assume temporary care of your child and/or has your permission to pick your child up from school if you cannot be reached:

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

WHILE participating in school activities and/or attending FIELD TRIPS, I authorize treatment by a licensed medical physician/dentist of the above minor in the event of a medical/dental emergency that, in the opinion of the attending physician/dentist, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. The authority granted is only to be exercised after reasonable efforts have been made to reach me *if time so permits*. If I cannot be reached, I authorize the school Principal, teacher certified CPR/first aide staff, or my designated contact person to call or drive my child to the physician or dentist listed above, or the nearest hospital if emergency care is needed. An ambulance may be called if necessary. This release form is completed and signed below of my own free will and is for the sole purpose of authorizing necessary medical treatment under emergency circumstances in my absence. **Special Accommodations:** Students with disabilities who need special accommodations to participate in activities should inform the school, prior to activity date.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## The Wisconsin Home Language Survey

*This survey is given to all students enrolling in Wisconsin Schools.*

### Purpose

The information on this form helps us identify students who may need help to develop the English language skills necessary for success in school. Language testing may be necessary to determine if language supports are needed by your child.

Answers will not be used for determining legal status or for immigration purposes. If your child is identified as eligible for English language services, you may decline some or all of services offered to your child.

### Student Information

Date:		
First Name:	Middle Initial:	Last Name:
School Name:	Grade:	Date of Birth (mm/dd/yyyy):
District:		District ID:
Language(s) other than English used by the student:		

### Parent/Guardian Information:

First Name:
Last Name:
Relationship to Student:
First Name:
Last Name:
Relationship to Student:

### Parental/Guardian Language Preferences Used for School Communication (may be multiple):

Parental/Guardian Name: \_\_\_\_\_  
 Oral: \_\_\_\_\_  
 Written: \_\_\_\_\_

Parental/Guardian Name: \_\_\_\_\_  
 Oral: \_\_\_\_\_  
 Written: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Please check "yes" or "no" and follow the instructions.

1. Was the first language used by this student English?

Yes: Go to Question 2.

No: Go to Question 3.

2. When at home, does this student hear or use a language other than English more than half of the time?

Yes: Go to Question 4.

No: Student is not eligible for ELP Screening. Survey is complete.

3. When at home, does this student hear or use a language other than English more than half of the time?

Yes: School District will administer ELP screener. Record other language(s). Survey is complete.

No: Go to Question 4.

4. When interacting with their parents or guardians, does this student hear or use a language other than English more than half of the time?

Yes: School District will administer ELP Screener. Record other language(s). Survey is complete.

No: Go to Question 5.

5. When interacting with caregivers other than their parents or guardians, does this student hear or use a language other than English more than half of the time?

Yes: School District will administer ELP screener. Record other language(s). Survey is complete.

No: Go to Question 6.

6. When interacting with their siblings or other children in their home, does this student hear or use a language other than English more than half of the time?

Yes: School District will administer ELP screener. Record other language(s). Survey is complete.

No: Go to Question 7.

7. Is this student a Native American, Native Alaskan, or Native Hawaiian?

Yes: Go to Question 8.

No: Go to Question 9.

8. Is this student's language influenced by a Tribal language through a parent, grandparent, relative, or guardian?

Yes: School District will administer ELP screener. Survey is complete.

No: Go to Question 9.

9. Has this student recently moved from another school district where they were identified as an English Learner?

Yes: School District will re-screen the student if they meet the criteria for re-screening.

No: Student is not eligible for ELP Screening. Survey is complete.



NEW STUDENT MEDICAL RECORD

WISCONSIN RAPIDS PUBLIC SCHOOLS

This information will be shared with appropriate school personnel only.

Student Name: \_\_\_\_\_ Gender: M / F Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone number: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone # \_\_\_\_\_ Copy of Immunizations:  Yes  No

Dentist: \_\_\_\_\_ Phone # \_\_\_\_\_

Does your child take prescribed medication?  Yes  No If Yes...  Taken At Home  Taken At School

What medication: \_\_\_\_\_

What for: \_\_\_\_\_

MEDICAL HISTORY (check items child has had)

Table with 3 columns of medical conditions: Arthritis, Asthma, Attention Deficit Disorder, Bladder/Kidney Infection, Blood Disorder, Bowel Problems, Chicken Pox, Diabetes, Ear Infections (chronic), Epilepsy/seizure disorder, Emotional/Mental Illness, Heart Disease/Defect, High Blood Pressure, Premature Birth, Traumatic Brain Injury, Other.

Additional Information \_\_\_\_\_

Vision Problem (explain) \_\_\_\_\_

Does your child wear glasses? Yes \_\_\_\_\_ No \_\_\_\_\_ Does your child wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

Hearing Problem (explain) \_\_\_\_\_

Student has allergies to:  Animals  Foods  Insects  Medication  Seasonal

Specify Allergies: \_\_\_\_\_

Describe Allergic Reaction: \_\_\_\_\_

Does your child require an EpiPen? Yes \_\_\_\_\_ No \_\_\_\_\_ Antihistamine (Benadryl) Yes \_\_\_\_\_ No \_\_\_\_\_

Serious accidents: \_\_\_\_\_

Operations (what and when): \_\_\_\_\_

Are there any special medical or other concerns that the school should be aware of to enable us to design an educational program for your child? \_\_\_\_\_

Are there any health conditions regarding your child that you would like to discuss with the school nurse? Yes \_\_\_\_\_ No \_\_\_\_\_

(For Kindergarten Only) Is your child toilet trained? Yes \_\_\_\_\_ No \_\_\_\_\_

Parent Signature

Date

## 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 2021-2022 School Year and the Following School Years**

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 11	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			1 Mening
Grade 12	4 DTP/DTaP/DT	1 Tdap	4 Polio	2 MMR	2 Var	3 Hep B			2 Mening

- 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 5, 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 3<sup>rd</sup> dose after the 4<sup>th</sup> birthday, further doses are not required. **Note:** A dose four days or less before the 4<sup>th</sup> birthday is also acceptable.
- DTaP/DTP/DT vaccine for children entering Kindergarten: Each student must have received one dose after the 4<sup>th</sup> birthday (either the 3<sup>rd</sup>, 4<sup>th</sup>, or 5<sup>th</sup> dose) to be compliant. **Note:** a dose four days or less before the 4<sup>th</sup> 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 3<sup>rd</sup> dose after the 4<sup>th</sup> birthday, further doses are not required. **Note:** a dose four days or less before the 4<sup>th</sup> 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 1<sup>st</sup> 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 1<sup>st</sup> 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 physician, physician assistant, or advanced practice nurse prescriber must document a reliable history of varicella disease by indicating that the student has had varicella and signing the Student Immunization Form (DHS Form 04020L). Current Wisconsin students with a parental report of varicella prior to February 1, 2023 are not required to receive Varicella vaccine.
- One dose of Meningococcal vaccine (serogroup A,C,W,Y) is required for students entering 7<sup>th</sup> grade, and a booster dose is required for students entering 12<sup>th</sup> grade. Students are assessed for this requirement in 7<sup>th</sup> grade and 12<sup>th</sup> grade only. Current Wisconsin students in 8<sup>th</sup>-11<sup>th</sup> grade will not be assessed for this requirement until they enter 12<sup>th</sup> grade. A second dose is not required for students who received their first dose of MenACWY at age 16 years or older.





## 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.

<b>Step 1 Personal Data</b>		<b>Please Print</b>			
Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year
Name of Parent/Guardian/Legal Custodian		Address (Street, City, State, ZIP Code)		Phone Number	

<b>Step 2 Immunization History</b>					
List the <b>month, day, and year</b> your child received each of the following immunizations. If you do not have an immunization record for this student, contact your doctor or public health department to obtain it. You may also use the Wisconsin Immunization Registry: <a href="https://www.dhfs.wisconsin.gov/immunization/registry">https://www.dhfs.wisconsin.gov/immunization/registry</a>					
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
<b>DTaP/DTP/DT/Td</b> (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) <input type="checkbox"/> Tdap <input type="checkbox"/> Td					
<b>Polio</b>					
<b>Hepatitis B</b>					
<b>MMR</b> (Measles, Mumps, Rubella)					
<b>Varicella</b> (Chickenpox) Vaccine					
<b>Meningococcal</b> (serogroup ACWY)					
Students with a reliable history of varicella disease are not required to receive the varicella vaccine. Signature from physician, physician assistant, or advanced nurse prescriber required. <input type="checkbox"/> I attest that this student has a reliable history of varicella disease,			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 <b>yes</b> , provide laboratory report(s)		
_____ <b>SIGNATURE</b> – Health Care Provider      Date Signed					

<b>Step 3 Requirements</b>
Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

<b>Step 4 Compliance Data</b>
<p><b>Student Meets All Requirements</b>                  Sign at Step 5 and return this form to school.                  _____ Or _____</p> <p><b>Student Does Not Meet All Requirements</b>                  Check the appropriate box below, sign at Step 5, and return this form to school. <b>Please note that incompletely immunized students may be excluded from school if an outbreak of one of these diseases occurs.</b></p> <p><input type="checkbox"/> Although my child has <b>not</b> received <b>all</b> the required doses of vaccine, the <b>first dose(s)</b> has/have been received. I understand that the <b>second dose(s)</b> must be received by the 90th school day after admission to school this year, and that the <b>third dose(s)</b> and <b>fourth dose(s)</b> 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.</p> <p><b>Note: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.</b></p> <p><b>Waivers</b> (List in Step 2 above, the date(s) of any immunizations your child has already received)</p> <p><input type="checkbox"/> <b>For health reasons</b> this student should not receive the following immunizations _____</p> <p>_____  <b>SIGNATURE</b> – Physician      Date Signed</p> <p><input type="checkbox"/> <b>For religious reasons</b>, I have chosen not to vaccinate this student with the following immunizations (check all that apply)  <input type="checkbox"/> DTaP/DTP/DT/Td   <input type="checkbox"/> Tdap,   <input type="checkbox"/> Polio   <input type="checkbox"/> Hepatitis B   <input type="checkbox"/> MMR (Measles, Mumps, Rubella)   <input type="checkbox"/> Varicella   <input type="checkbox"/> MenACWY</p> <p><input type="checkbox"/> <b>For personal conviction reasons</b>, I have chosen not to vaccinate this student with the following immunizations (check all that apply)  <input type="checkbox"/> DTaP/DTP/DT/Td   <input type="checkbox"/> Tdap   <input type="checkbox"/> Polio   <input type="checkbox"/> Hepatitis B   <input type="checkbox"/> MMR (Measles, Mumps, Rubella)   <input type="checkbox"/> Varicella   <input type="checkbox"/> MenACWY</p>

<b>Step 5 Signature</b>
This form is complete and accurate to the best of my knowledge. Check one: (I <b>do</b> <input type="checkbox"/> I <b>do not</b> <input type="checkbox"/> ) 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.
_____ <b>SIGNATURE</b> - Parent/Guardian/Legal Custodian or Adult Student      Date Signed