Date Correction Plan Due	NONCOMPLIANCE STATEMENT AND CORRECTION PLAN	TO FILE A COMPLAINT CALL
5/31/2025		608-422-6765

Use of Form: This form is used by certification / licensing staff to identify statute and / or administrative rule violation(s) and to outline imposed plans of correction, if applicable. This form is used by certified operators / licensed centers to meet the requirements of DCF 202.065, DCF 250.04(2)(i) and (3)(d), DCF 251.04(2)(L) and (3)(f)., DCF 252.41(1)(L) and (2)(k). Failure to submit an appropriate correction plan by the due date listed above may result in sanctions identified in the statute and / or administrative rule. Public Schools may submit plans of correction however are not required to do so.

Instructions: The Noncompliance Statement below identifies the violation(s) of child care statute and / or administrative rule identified by the certification / licensing specialist. Complete the section labeled "Correction Plan" by indicating the steps that will be taken to address and correct each of the listed noncompliance(s). Identify expected completion date(s) for each item. Return the original to your certification / licensing specialist for approval and retain a copy. If this is a licensed child care, post your copy of the noncompliance statement and correction plan near the license in accordance with Wis. Stat. 48.657. This request for a correction plan is not an order imposing a sanction or penalty pursuant to Wis. Stat. 48.715. If the department decides to apply a statutory sanction and / or penalty for facts arising from this finding or a future finding, you will be given a notice of the sanction and / or penalty and your appeal rights.

Name - Certified Operator / Licensed Center		Provider Number / Facility ID Number	
Hoocak Ee Cooni Waziperes Hocira		1000556721 / 008 - 2002652	
Address - Facility (Street, City, State, Zip Code) E8873 Winneshiek Dr Wisc Dells WI 539659798		**Telephone Number** 608-253-3675	**Date - Regulation Visit** 5/12/2025

	Rule/Statute Number Noncompliance Statement	Correction Plan	Expected Completion Date	Verification Date
1	250.05(2)(d)1. **Staff File - Physical Examination - Form** Description: Staff A, who has been working longer than 30 days, is missing a physical examination report stating they are free of communicable diseases and are capable of working with young children.	TA received a copy of the staff health report to take to her Dr. Health report signed on 5/16/25.		

NAME - Agency Worker
Amy Anderson

Date Issued
5/17/2025

SIGNATURE - Certified Operator or Designee / Licensee or Designee

Mary Thundercloud - Eagle

Date Signed
5/17/2025

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

dcf.wisconsin.gov

STAFF HEALTH REPORT – LICENSED CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 250.05(2)(d) and DCF 251.05(2)(a)3.a. of the Wisconsin Administrative Code. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: The examining health professional will complete this form, sign Section B, and return the completed form to the individual for placement in the staff file.

A. STAFF INFORMATION FCC: provider, employee, substitute. GCC: persons who work directly with children except volunteers.

Name (Last, First, MI)	Position Title
Mike, Cheyenne F	Assistant Teacher

B. PHYSICAL EXAMINATION

☒ Yes ☐ No I certify based upon my examination that this person appears free of symptoms of illness, including tuberculosis, or communicable disease that may be transmitted through normal contact.

☒ Yes ☐ No I certify based upon my examination that this person appears to be physically able to work with children.

NOTE: This individual will be in contact with children receiving child care services and may be responsible for the physical care and social development of young children during the hours child care is provided. Some lifting of young children may be required.

Comments:

SIGNATURE – MD, PA or other Health Check Provider	Name – Examining Health Professional (Type or Print)
[signature]	Kiana Beaudin PA-C
Address – Health Professional Office (Street, City, State, Zip)	Date Signed (mm/dd/yyyy)
S2845 White Eagle Rd Baraboo WI 53913	05/16/2025

Health Hx AS

HO-CHUNK NATION
DEPARTMENT OF HEALTH

Cheyenne F Mike

Chart No. : 9843

DOB: 01/13/98

TB Skin Testing Consent and Record

Date: 10/28/24 Telephone: (___)_____

Sex:_____ Race/Country of Origin_____

Address:_____ City:_____ State:_____ Zip:_____

	Yes	No
1. Have you had a previous TB Skin Test? If yes, date:_____ Results: Positive ☐ Negative ☐	☐	☒
2. Have you ever been treated for TB? If yes, when, where and by whom?_____	☐	☒
3. Have you been recently exposed to someone with TB? If yes, by whom?_____	☐	☒
4. Have you been vaccinated with a live virus vaccine during the past six weeks?	☐	☒
5. Have you had any periods of illness in the last month that lasted more than two days? If yes, with what? _____	☐	☒
6. Are you currently taking (or recently stopped taking) any corticosteroid or other immunosuppressive agent?	☐	☒
7. Has a nurse or physician informed you that you are infected with Human Immunodeficiency virus (HIV) or AIDS?	☐	☒
8. Have you had a BCG vaccine to prevent tuberculosis? If yes, how often and at what ages?_____	☐	☒
9. Can you return in 48-72 hours to have the test read?	☒	☐
10. What was the reason for testing today? Work		

I request that I/My Child be given a tuberculin skin test.

Signature: Cheyenne Mike Date: 10/28/24

	1st test	2nd test
Date Administered	10/28/24	
Time Administered	2:20 pm	
Antigen Strength	STU PPD 0.1ml	STU PPD 0.1ml
Site	Left forearm	
Manufacturer	PAR	
Lot Number	78993	
Expiration Date	4/2024	
Date Opened	10/28/24	
RN Signature	Thomasa Charles RN	
Date Read	10/31/24	
Time Read	8:52 am	
Results	0mm negative	
RN Signature	Austin Zaika	

Ho-Chunk Health Care Center
N6520 Lumberjack Guy Road
Black River Falls, WI 54615
Ph. 715-284-9851 FAX 715-284-5150

House of Wellness
S2845 White Eagle Rd
Baraboo, WI 53913
Ph. 888-552-7889 FAX 608-355-9643

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