

**Independent School District #282  
St. Anthony - New Brighton**

**Health and Physical Examination Form**

Name \_\_\_\_\_ MS/HS \_\_\_\_\_  
Last First M.I. Birth date M or F School Grade  
 Parent/Guardian \_\_\_\_\_

**Parent: Please complete this section.**

Please circle any condition the student has had:

- |            |                       |                     |                               |
|------------|-----------------------|---------------------|-------------------------------|
| ADD/ADHD   | Diabetes              | Kidney Problems     | Tuberculosis                  |
| Asthma     | Emotional /Behavioral | Scoliosis           | Vision Loss/Corrective Lenses |
| Cancer     | Heart Disease         | Seizures            | Other _____                   |
| Depression | Hepatitis             | Sickle Cell Disease | _____                         |

	Yes	No	If yes, please explain
Hospitalization / illness / injury in past 12 months?			
Is the student on any medication? (include inhalers)			
Is physical activity limited in any way?			
Allergies? (Bee stings, food, medications, etc.)			

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

This information is being collected to provide for the student's health and safety at school. This data will be treated as private and will be recorded in the student health record. It will be shared only with school or emergency personnel on a "need to know" basis, unless you indicate otherwise. You are not legally required to supply this information; however, a lack of data may result in inadequate planning for your student. Physical exams are recommended but not required for school entrance.

**Physician: Please complete this section.**

Examination N=Normal AB=Abnormal			
Eyes		Genito-urinary	
Ears		Ortho-structural	
Mouth-Teeth		Ortho-posture	
Nose		Ortho-feet	
Throat		Skin	
Lymph nodes		Nervous system	
Thyroid		Speech	
Heart		Nutrition	
Lungs		Emotional Status	
Abdomen			

Measurements	
Blood Pressure	
Height	
Weight	
Hgb / Hct	
Urine	
Lead	
Vision: R 20/ _____ L 20/ _____ w/glasses Yes No	
Hearing: R _____ L _____ w/hearing aid Yes No	

Developmental Screening	
Yes	No
Date Screened	_____
Screening Test	_____
Results	_____
	_____
	_____

- Physical activities should be restricted: No \_\_\_\_\_ Yes \_\_\_\_\_ (Specify)
- There is a condition that may result in an emergency: No \_\_\_\_\_ Yes \_\_\_\_\_ (Specify)
- There is a condition that may interfere with learning: No \_\_\_\_\_ Yes \_\_\_\_\_ (Specify)

Problems as indicated above, on-going therapy, and medication – Plan and Recommendations		
_____		
Physician's Signature _____	Date of Examination _____	Phone _____
Physician's Name _____	Address _____	
<small>Please print</small>		



# Pupil Immunization Record

FOR SCHOOL USE ONLY

- Complete; booster required in \_\_\_\_\_
- In process; 8 mos. expires \_\_\_\_\_
- Medical exemption for \_\_\_\_\_
- Conscientious objection for \_\_\_\_\_

Name \_\_\_\_\_ Student Number \_\_\_\_\_

Birthdate \_\_\_\_\_

Minnesota Statutes Section 121A.15 requires children enrolled in a Minnesota school to be immunized against certain diseases, allowing for specified exceptions. This form is designed to provide the school with information required by the law.

**Medical exemption:** No student is required to receive an immunization if they have a medical contraindication or laboratory evidence of immunity. To receive a medical exemption, a physician must sign the following statement:

Enter the MONTH, DAY, and YEAR for all vaccines the pupil received. DO NOT USE (✓) or (x). Vaccines/doses in shaded boxes are recommended but not required by law.

*I certify that immunization is contraindicated for medical reasons or that laboratory confirmation of adequate immunity exists for the following immunizations:*

Type of Vaccine	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Diphtheria, Tetanus, and Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT) - pediatric formulation (<7 yrs)					
Tetanus and Diphtheria (Td) - adult formulation (7yrs)					
Polio (IPV, OPV)					
Measles, Mumps, and Rubella (MMR) (minimum age: 12 mos)					
Hepatitis B (hep B) *					
Varicella (chickenpox)**					
Pneumococcal Conjugate (PCV)**					
Haemophilus influenzae type b (Hib)***					

\* Hepatitis B is required for kindergarten and 7<sup>th</sup> grade.

\*\* Varicella vaccine will be required starting fall 2004.

\*\*\* PCV and Hib vaccines are recommended only for children through age 4 years.

Note for school personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+Hib, Hib+HBV) in each applicable space.

Indicate immunization status and source of above information by choosing one of the following:

I certify that this student has received all immunizations required by law.

Signature of parent/guardian or physician/public clinic

Date

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B (K + 7<sup>th</sup>), varicella (K + 7<sup>th</sup>), measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months. The dates on which the remaining doses are to be given are:

Signature of physician/public clinic

Date

Signature of physician

Date

**Conscientious exemption:** No student is required to have an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian. To receive this exemption, a parent or legal guardian must complete and sign the following statement and have it notarized:

*I certify by notarization that immunization for my child is contrary to my conscientiously held beliefs. Indicate vaccine(s):*

Signature of parent or legal guardian

Date

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Signature of notary

### History of varicella disease:

*I certify that this child had chickenpox disease on this date: \_\_\_\_\_ (MO/YR) and therefore does not need a varicella shot.*

Signature of parent/legal guardian or physician/public clinic

Date

### Additional exemptions

- **Children less than 7 years of age:** The 5<sup>th</sup> dose of DTaP/DTP/DT (similarly, the 4<sup>th</sup> dose of polio vaccine) is not necessary if the 4<sup>th</sup> DTaP/DTP/DT (3<sup>rd</sup> dose of polio) was administered after the 4<sup>th</sup> birthday.
- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DTTd and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Td booster at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7<sup>th</sup> birthday but before their 11<sup>th</sup> birthday. Instead, it will be required 10 years after the date of the most recent dose. Enforcement of the Td booster requirement will be reinstated in the fall of 2004 for all 7<sup>th</sup>-12<sup>th</sup> graders.
- **Students 11-15 years of age:** A 3<sup>rd</sup> dose of hepatitis B vaccine is not required for those students who provide documentation of the alternative 2-dose schedule.
- **Students 7 years of age or older:** Do not need pertussis vaccine.
- **Students 18 years of age or older:** Do not need polio vaccine.