

**Please mail form directly to the school your child is attending by August 15.

ST. CLOUD AREA SCHOOL DISTRICT 742

PHYSICAL FORM

This form is confidential.

Name _____ Male _____ Female _____ Birthdate _____
 Address _____ Phone _____
 Parent/Guardian _____
 Doctor _____ Dentist _____
 Last physical exam _____ Last dental exam _____

Significant Past History

Year	Year
Allergy (specify)	ADHD ADD
Asthma	Developmental Delay
Chicken Pox (Disease)	Seizure History
Congenital Defect (specify)	Vision Glasses ____ Yes
Diabetes	Hearing
Heart Condition	Surgeries (specify)
Neurologic (specify)	T & A
Orthopedic (specify)	Myringotomy Tubes, Hernia
	Other

Health Examination
(To be completed by Physician.)

Examining Physician's Name (Print) _____
 Ht. _____ Wt. _____ BMI _____ Pulse _____ BP _____ Urinalysis _____ HGB _____
 Eyes _____
 Ears _____ Orthopedic/Scoliosis _____
 Nose _____ Skin _____
 Throat _____ Allergies (if so, what?) _____
 Glands _____
 Lungs _____ Nutrition _____
 Heart _____ Serious Illnesses _____
 Nervous System _____

Please review/record immunizations on reverse side and update for school requirements as needed.

Does student require medication on a daily or episodic routine?

Name of medication: _____

Dose: _____ Frequency: _____

Condition being treated: _____

*Please include separate doctor's order if medication will be taken at school.

Significant Development History _____

History of: Hearing Problem _____ Speech Problem _____

History of: Social or Emotional Problem _____

List conditions which may limit participation in:

A. Classroom activity _____

B. Physical education _____

C. Competitive sports _____

Any special health problems, recommendations and/or comments _____

Approved for: Full Activity _____ **Limited Activity** _____

Date _____ **Examining Physician** _____ **M.D.**

I hereby release this information to the Health Service of District 742 and give the licensed school nurse permission to clarify the information with the Physician if the need arises.

PARENT/GUARDIAN SIGNATURE



Pupil Immunization Record

FOR SCHOOL USE ONLY
 () Complete; booster required in _____
 () In process; 8 mos. Expires _____
 () Medical exemption for _____
 () Conscientious objection for _____

Name _____ Birthdate _____ Student Number _____

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.

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

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) – formulation for <7 yrs					
Tetanus and Diphtheria (Td, Tdap) – formulation for ≥7 yrs					
Polio (IPV, OPV)					
Measles, Mumps, and Rubella (MMR) (minimum age: on or after 1st birthday)					
Hepatitis B (hep B)*					
Varicella (chickenpox)** (minimum age: on or after 1st birthday)					
Pneumococcal Conjugate (PCV)***					
Haemophilus influenzae type b (Hib)***					
Meningococcal (MPSV, MCV)					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Rotavirus					

* Hepatitis B is required for kindergarten and 7th grade.
 ** Varicella vaccine or disease history is required for kindergarten and 7th grade.
 *** 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 + 7th), varicella (K + 7th), 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

Medical exemption: No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student to receive a medical exemption, a physician must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was either laboratory confirmed, or in the case of varicella, medically diagnosed or adequately described to me by the parent to indicate past varicella infection.

Exempted immunization(s): _____

For varicella disease only: Year of disease _____

 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. However, not following vaccine recommendations may endanger the health or life of the student or others they come in contact with. 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

Additional exemptions

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

Immunization Program
 P.O. Box 64975
 St. Paul, MN 55164-0975
 651-201-5503 or 1-800-657-3970
 www.health.state.mn.us/immunize
 (1/2010) IC#140-0155