Robbinsdale Area Schools--District #281

Health and Physical Examination Form (Pre-school / Elementary)

Name_______________ _______________ ______ __________ ______ ______ ______
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

Call 763-504-4180 to schedule a *free* comprehensive developmental screening required before kindergarten.

If a comprehensive developmental screening is completed in another location, a copy of the complete screening must be sent to:
Cavanagh Early Childhood Screening
5400 Corvallis Ave. N.
Crystal, MN 55429
Fax 763-504-5339

1. Physical activities should be restricted: No_____ Yes_____ (Specify)
2. There is a condition that may result in an emergency: No_____ Yes_____ (Specify)
3. 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_____________________________
Please print

5/05

Please complete immunization information found on reverse side.

Pupil Immunization Record

Name____________________ Birthdate __________ Student Number __________

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

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 laboratory confirmed. ***(For varicella disease see ** below)***

Exempted immunization(s):

Signature of physician/nurse practitioner/physician assistant __________ Date

****History of varicella disease only.** In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in __________. Year

Signature of physician/nurse practitioner/physician assistant

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
(4/2010) IC#140-0155