ISD 709 Duluth Public Schools

HEALTH HISTORY & PHYSICAL AND IMMUNIZATION FORM

Independent School District # 709
School Health Services

STUDENT INFORMATION - To be completed by parent

Name________________________________ ❒ Male ❒ Female Birth Date____/____/____

Address________________________________ Phone # ______________

Father or Guardian____________________ Place of Work____________ Phone # ______________

Mother or Guardian____________________ Place of Work____________ Phone # ______________

In Emergency, Notify________________________________ Phone # ______________

Physician____________________ Dentist ____________________

School____________________ Grade _______ Home Room ______________

Last School Attended ____________________ City ______________

PLEASE CHECK (✓) THE HEALTH CONCERNS YOUR CHILD HAS HAD:

❒ Allergy (Specify____________)	❒ Epilepsy	❒ Red Measles (Rubeola)	❒ Scarlet fever
❒ Asthma	❒ Eye Trouble	❒ German Measles (Rubella)	❒ Strep Throat
❒ Eczema	❒ Frequent Headaches	❒ Mumps	❒ Stomach Trouble
❒ Hayfever	❒ Hearing Trouble	❒ Nervousness	❒ Tonsillitis
❒ Chickenpox	❒ Ear Aches	❒ Bone or Muscle Trouble	❒ Tuberculosis
❒ Frequent Colds	❒ Draining Ear	❒ Pneumonia	❒ Whooping Cough
❒ Diabetes	❒ Heart Trouble	❒ Rheumatic Fever	

Comment on major illness, operations, injuries or other health problems________________________________

____

Is your child on any medication on a regular or long-term basis? ❒ Yes ❒ No

If YES, please specify________________________________

Has your child ever been hospitalized? ❒ Yes ❒ No If YES, for what and at what age? ____________________

____

DENTAL EXAMINATION – To be completed by dentist

Dental Examination:

1. Normal dentition present............... ❒ Yes ❒ No
2. Normal occlusion .... ❒ Yes ❒ No
3. Soft tissues normal .... ❒ Yes ❒ No
4. Abscesses or infection present........ ❒ Yes ❒ No
5. Dental Caries ❒ Rampant ❒ Moderate ❒ None
6. Dental Care... ❒ Routine treatment required
   ❒ Urgent treatment required
   ❒ Topical fluoride applied
   ❒ No further treatment required at this time

Comments or recommendations to school nurse: ____________________

____

____

This is to verify that:

____

Name of Student

Has had all dental treatment that is necessary at this time.

______________ ________________________________DDS

Date Signature of DENTIST

HEALTH EXAMINATION – To be completed by physician

Name ______________________ Blood Pressure ______________________

Height__________ Weight__________

List Positive Findings of Complete Medical Examination:

____

____

____

____

____

Hgb. Or Hct. ______________________

Urine______________________

Eyes: Vision ……………………R 20 / _______ L 20 / _______

Glasses Worn……………………❒ Yes ❒ No

Contacts …………………………❒ Yes ❒ No

Hearing……………………………R _______ L _______

Scoliosis……………………………_______Neg. _______ Pos.

	Normal	***Abnormal***
Developmental: Gross Motor …………………………	_______	_______
Fine Motor………………………………	_______	_______
Screening tool used:____________________		
Concepts …………………………	_______	_______
Speech………………………… .	_______	_______
Screening tool used____________________		

Recommendations regarding treatment and correction: ____________________________________

Any condition which may result in an emergency? ❒ Yes ❒ No If YES, please specify__________________________

____

List other health concerns that could interfere with learning: ______________________________

____

What emotional problems, if any, should be watched for? ______________________________

____

List medications the child is on: ______________________________

____

Has this child had chicken pox disease? ❒ Yes ❒ No Year of disease? ______________________

Is there a condition which may limit participation in:

A. Classroom activity? ❒ Yes ❒ No

B. Physical Education? ❒ Yes ❒ No

C. Competitive sports? ❒ Yes ❒ No

If YES, please specify ____

Comments and recommendations: ____________________________________

____

____

____

Date ______________________ Signature____________________________________M.D.

Also, complete documentation of immunization on next page, or

Attach copy of clinic immunization record.

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunization Form

Name________________________________ Birthdate______________

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months	12 -24 months	At Kindergarten	At 7th grade	At 12th grade
Hepatitis B					
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)					
Haemophilus influenzae type b (Hib)					
Pneumococcal (PCV)					
Polio					
Measles, Mumps, Rubella (MMR)					
Chickenpox (varicella)					
Hepatitis A					
Tetanus, Diphtheria, Pertussis (Tdap)					
Meningococcal (MCV4)					

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.
   - Provide consent to share immunization information (optional) in section 3.

DEPARTMENT OF HEALTH
Immunization Program (2019)
www.health.state.mn.us/immunize

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name ____________________

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: ____________________ Date: ____________
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: ____________________ Date: ____________
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me

on ____________ (date)

by ____________________
(name of parent or guardian)

Notary Signature:

____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF

____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year ____________

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: ____________________ Date: ____________
(of health care practitioner*, representative of a public clinic, or parent/ guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: ____________________ Date: ____________
(of parent/guardian)