Name _____
(Last) (First) (Middle)

Birthdate_____Gender_____Grade_____ID#_____

- Minnesota law mandates that all children participate in **Early Childhood Screening** prior to Kindergarten entrance. The required components are identified with an asterisk *.
- For further information, call (612) 668-3711.

MINNEHAHA ACADEMY

Preschool – 5th Grade HEALTH EXAMINATION

* TYPE of VACCINE	1ST Dose MM/DD/YY	2nd Dose MM/DD/YY	3rd Dose MM/DD/YY	4th Dose MM/DD/YY	5th Dose MM/DD/YY
DTaP (Diphtheria, Pertussis, Tetanus)					
Td/Tdap (Tetanus, Diphtheria booster)					
HIB (Haemophilus Influenza b)					
POLIO (IPV)					
HEPATITIS B (HBV)					
HEPATITIS A					
MMR (Measles, Mumps, Rubella)					
VARICELLA (Chickenpox)					
PNEUMOCOCCAL					

Legal Exemptions on backside

	Normal	Abnormal
Eyes		
cover test		
corneal reflection		
Ears		
Mouth – dental		
Throat		
Nose		
Lymph nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Hernia	❒no	❒ yes
Genito-urinary		
Tanner staging (circle one) I, II, III, IV, V		
Musculoskeletal		
Spine		
Extremities		
Skin		
Neurological		
Nutritional status		
Emotional status		
Behavior		
Speech		

* Height_____ins. Weight_____lbs. BMI _____ Blood Pressure _____/_____

* Vision R 20/____ L 20/_____ Corrected: ❒ yes ❒no

* Hearing: ❒ Normal ❒ Abnormal Hearing aid(s): ❒ yes ❒no

	500 (25)dB	1000 (20)dB	2000 (20)dB	4000 (20)dB
Right				
Left				

	Date	Results
Hemoglobin/Hct		
Urinalysis		
Tuberculin (PPD)		mm
Chest x-ray		
Blood lead level		µg/dL

Allergies: _____

Physical Ed. restrictions:_____

_____

There is a condition that may result in an emergency:
(if yes, elaborate below) ❒ yes ❒ no
There is a condition that may interfere with learning:
(if yes, elaborate below) ❒ yes ❒ no

* **Developmental screening date**: _____

Areas screened	Screening tool used	Results
❒ Fine/gross motor ❒ Cognition ❒ Speech / language ❒ Social/emotional ❒ Behavior	❒ MPSI-R ❒ Ireton ❒ ASQ ❒ Other (describe)	❒ Pass ❒ Refer to Early Childhood Special Education ❒ Areas of Concern: ❒ Comments:

Describe any abnormal findings or chronic conditions.

Health Concerns	Medication/Treatment/Referral Plan	Recommendations for School

Note: a separate form is required for all medications and treatments to be administered at school.

_____ _____ _____
Signature and title of health care provider | Print name | Date of physical exam

_____ _____ _____
Clinic name | Phone | Fax

Please return this form to your school nurse.

Student Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)
Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Received all required immunizations:

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

_____

Signature of Parent / Guardian OR Physician / Public Clinic

_____ Date

B. Will complete required immunizations within the next 8 months:

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, 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

2. Exemptions to School Immunization Law. Complete A and/or B to indicate type of exemption.

A. 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, nurse practitioner, or physician assistant 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). List 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 (If disease occured before September 2010, a parent can sign.)

B. Conscientious exemption:

No student is required to have an immunization that 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. In a disease outbreak schools may exclude children who are not vaccinated in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

_____

Signature of parent or legal guardian

_____ Date

Subscribed and sworn to before me this:
_____ day of _____ 20_____

_____

Signature of notary

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

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

_____

Signature of parent or legal guardian Date