

Name _____
 (Last) (First) (Middle)

Birthdate _____ Gender _____ Grade _____ ID# _____



6th – 12th Grade HEALTH EXAMINATION

| * TYPE of VACCINE | 1 st Dose MM/DD/YY | 2 nd Dose MM/DD/YY | 3 rd Dose MM/DD/YY | 4th Dose MM/DD/YY | 5 th Dose MM/DD/YY |
|---------------------------------------|----------------------------------|----------------------------------|----------------------------------|----------------------|----------------------------------|
| DTaP (Diphtheria, Pertussis, Tetanus) | | | | | |
| Td/Tdap (Tetanus, Diphtheria booster) | | | | | |
| POLIO (IPV, OPV) | | | | | |
| HEPATITIS B (HBV) | | | | | |
| MMR (Measles, Mumps, Rubella) | | | | | |
| VARICELLA (Chickenpox) | | | | | |
| Meningococcal (MCV) | | | | | |
| Human Papillomavirus (HPV) | | | | | |
| Other: (Specify) | | | | | |

Legal Exemptions on backside.
 Shaded immunizations are not required for school.

| | Normal | Abnormal |
|---|-----------------------------|------------------------------|
| Eyes | | |
| Ears | | |
| Mouth - dental | | |
| Throat | | |
| Nose | | |
| Lymph nodes | | |
| Thyroid | | |
| Heart | | |
| Pulses | | |
| Lungs | | |
| Abdomen | | |
| Hernia | <input type="checkbox"/> no | <input type="checkbox"/> yes |
| Genito-urinary | | |
| Tanner staging (circle one) I, II, III, IV, V | | |
| Musculoskeletal | | |
| Spine | | |
| Extremities | | |
| Skin | | |
| Neurological | | |
| Nutritional status | | |
| Emotional status | | |
| Behavior | | |

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: _____

► REQUIRED FOR SPORTS

Any student who intends to participate in interscholastic athletics and/or cheerleading activities must have on file in the school, a record of a physical examination performed by a licensed health professional within the previous three years, with an indication of permission to participate in inter-school athletics.

| | Permitted | Restricted | Restricted activity |
|-----------------------------------|-----------|------------|---------------------|
| Physical ed. class | | | |
| All Inter-school athletics | | | |
| Collision Contact Sports | | | |
| Limited Contact Sports | | | |
| Non-contact Sports | | | |

A copy of the official MN High School League Physical form can be printed at: <http://athletics.mpls.k12.mn.us>

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

There is a condition that may interfere with learning: yes no

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 _____

Instructions, please complete:

Box 1 to certify the child's immunization status

Box 2 to file an exemption (medical or conscientious)

Box 3 to provide consent to share immunization information (optional)

| | |
|--|---|
| <p>1. Certify Immunization Status. Complete A or B to indicate child's immunization status.</p> | |
| <p>A. Received all required immunizations: I certify that this student has received all immunizations required by law.</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of Parent / Guardian OR Physician / Public Clinic</p> <p>_____ Date</p> | <p>B. Will complete required immunizations within the next 8 months:</p> <p>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.</p> <p>The dates on which the remaining doses are to be given are:</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of Physician / Public Clinic</p> <p>_____ Date</p> |

| | |
|---|---|
| <p>2. Exemptions to School Immunization Law. Complete A and/or B to indicate type of exemption.</p> | |
| <p>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):</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of physician/nurse practitioner/physician assistant</p> <p>_____ Date</p> <p>*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)</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)</p> | <p>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):</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of parent or legal guardian</p> <p>_____ Date</p> <p>Subscribed and sworn to before me this: _____ day of _____ 20____</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of notary</p> |

| | |
|---|---|
| <p>3. Parental/Guardian Consent to Share Immunization Information (optional):</p> | |
| <p>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.</p> <p>I agree to allow school personnel to share my student's immunization documentation with Minnesota's immunization information system:</p> | |
| <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Signature of parent or legal guardian</p> | <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/> <p>Date</p> |