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***		***Normal***	***Abnormal***
Developmental:	Gross Motor ……..….	_____	_____	Concepts ……..…..….	_____	_____
	Fine Motor……..…….	_____	_____	Speech…… .	_____	_____
	Screening tool used:_____			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.

Immunization Form

Name_____ Birthdate_____

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.

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)