

Minnesota State Academies – PHYSICIAN’S EVALUATION REPORT

NOTE: Medical Doctor must complete this page.

Student Name	Birthdate	Weight	Height	BMI
Diagnosis/ICD-10 Code:				

Allergies: Does the student have any known **food, medication, insect or seasonal allergies**? NO ____ YES ____
If yes, list and describe allergic response and treatment:

Special Diet: Does the student have any **dietary restrictions** or require a **special diet**? NO ____ YES ____
If yes, describe/complete [MDE Special Diet Statement](#):

Does the student have a **physical condition which limits his/her participation in classroom activity, physical education, or competitive sports**? NO ____ YES ____ If yes, describe:

Medication (Seasonal, emergency, daily): NO ____ YES ____ If yes, list all, attach additional information.
Students must have a prescription/specific order for all medications, including over-the-counter medications.

Medication	Dose	Route	Frequency	Diagnosis/ purpose	Preferred Time Given	Alerts/ Comments

Diagnosis Action Plans: If yes, please describe and complete/attach an Action Plan for that diagnosis.

Seizures: NO ____ YES ____

Asthma: NO ____ YES ____

Diabetes: NO ____ YES ____

Epipen: NO ____ YES ____

Septo Optic Dysplasia: NO ____ YES ____

If the student has a complex medical problem, please document detailed guidelines for school management of these conditions.

PHYSICAL EXAMINATION RESULTS

Blood Pressure: _____ Pulse: _____ Resp.: _____ Lab results/other: _____

Physical findings/comments:

Recommended further evaluation/follow up? _____

Vaccination/Immunizations REVIEW: _____

PHYSICIAN’S VERIFICATION OF INFORMATION

Physician Name Printed: _____ Date of Student Exam: _____

Physician’s Signature: _____ Today’s Date: _____

Clinic Name/City: _____ Phone: _____