

# 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:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Allergy (Specify _____) | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Red Measles (Rubeola)    | <input type="checkbox"/> Scarlet fever   |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Eye Trouble        | <input type="checkbox"/> German Measles (Rubella) | <input type="checkbox"/> Strep Throat    |
| <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Mumps                    | <input type="checkbox"/> Stomach Trouble |
| <input type="checkbox"/> Hayfever                | <input type="checkbox"/> Hearing Trouble    | <input type="checkbox"/> Nervousness              | <input type="checkbox"/> Tonsillitis     |
| <input type="checkbox"/> Chickenpox              | <input type="checkbox"/> Ear Aches          | <input type="checkbox"/> Bone or Muscle Trouble   | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Frequent Colds          | <input type="checkbox"/> Draining Ear       | <input type="checkbox"/> Pneumonia                | <input type="checkbox"/> Whooping Cough  |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Heart Trouble      | <input type="checkbox"/> 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of DENTIST

\_\_\_\_\_  
DDS

## 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.**

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.

Birth to 6 months

12 -24 months

At Kindergarten

At 7th grade

At 12th grade

## Vaccine

Hepatitis B									
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)									
<i>Haemophilus influenzae</i> 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:

- 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.
- 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.

**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		
<i>Haemophilus influenzae</i> 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\*)

**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.

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.

**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)

Notary Stamp

by \_\_\_\_\_  
(name of parent or guardian)

Notary Signature: \_\_\_\_\_

STATE OF MINNESOTA, COUNTY OF \_\_\_\_\_

**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)