



**KINDERGARTEN PHYSICAL EXAMINATION FORM**

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOME PHONE #: \_\_\_\_\_  
 MOTHER'S NAME: \_\_\_\_\_ FATHER'S NAME: \_\_\_\_\_

**HEALTH HISTORY: TO BE COMPLETED BY PARENT AND PHYSICIAN**

*PLEASE CHECK ALL THAT APPLY*

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Lazy eye                   | <input type="checkbox"/> Seizure condition      | <input type="checkbox"/> Bowel/bladder problems |
| <input type="checkbox"/> Frequent ear infections    | <input type="checkbox"/> Attention difficulties | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Frequent throat infections | <input type="checkbox"/> Tics                   | <input type="checkbox"/> Chicken pox            |
| <input type="checkbox"/> Snores at night            | <input type="checkbox"/> Motor difficulties     | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Mouth breather             | <input type="checkbox"/> Speech difficulties    | <input type="checkbox"/> CMV                    |
| <input type="checkbox"/> Hearing loss               | <input type="checkbox"/> Behavior difficulties  | <input type="checkbox"/> HIV                    |
| <input type="checkbox"/> Allergies: Please specify  | <input type="checkbox"/> Complicated pregnancy  | <input type="checkbox"/> Seen by specialist     |
| <input type="checkbox"/> Food: _____                | <input type="checkbox"/> Premature: _____       | <input type="checkbox"/> Takes daily medication |
| <input type="checkbox"/> Med.: _____                |   | <input type="checkbox"/> Meds: _____            |
| <input type="checkbox"/> Insect: _____              |   |   |
| <input type="checkbox"/> Contact: _____             |   |   |
| <input type="checkbox"/> Environmental:             |   |   |
| <input type="checkbox"/> Specify: _____             |   |   |
| <input type="checkbox"/> Date: _____                |   |   |

I hereby give permission to school authorities to contact the family doctor for further information if necessary.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICAL EXAMINATION: TO BE COMPLETED BY PHYSICIAN**

HT: \_\_\_\_\_ WT: \_\_\_\_\_ TB TEST: \_\_\_\_\_ DATE: \_\_\_\_\_ RESULT: \_\_\_\_\_

**GENERAL APPRAISAL:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> _____ HT      | <input type="checkbox"/> _____ ALLERGIES     | <input type="checkbox"/> RESTRICTONS TO DIET/ACTIVITY: |
| <input type="checkbox"/> _____ WT      | <input type="checkbox"/> _____ Hgb           | _____  |
| <input type="checkbox"/> _____ EYES    | <input type="checkbox"/> _____ URINALYSIS    |  |
| <input type="checkbox"/> _____ VISION  | <input type="checkbox"/> _____ B/P           |  |
| <input type="checkbox"/> _____ EARS    | <input type="checkbox"/> _____ ORTHOPEDIC    | MD Signature: _____                                    |
| <input type="checkbox"/> _____ HEARING | <input type="checkbox"/> _____ SCOLIOSIS     | Date: _____  |
| <input type="checkbox"/> _____ NOSE    | <input type="checkbox"/> _____ LUNGS         | Phone: _____   |
| <input type="checkbox"/> _____ TEETH   | <input type="checkbox"/> _____ ABDOMEN       | Address: _____   |
| <input type="checkbox"/> _____ PALATE  | <input type="checkbox"/> _____ SKIN          | _____  |
| <input type="checkbox"/> _____ HEART   | <input type="checkbox"/> _____ LEAD EXPOSURE |  |

# Student Immunization Form

Student Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Student Number \_\_\_\_\_

Minnesota law requires children enrolled in school to be immunized against certain diseases or file a legal medical or conscientious exemption.

**FOR SCHOOL USE ONLY**

( ) Complete; booster required in \_\_\_\_\_

( ) In process; 8 mos. expires \_\_\_\_\_

( ) Medical exemption for \_\_\_\_\_

( ) Conscientious objection for \_\_\_\_\_

( ) Parental/guardian consent \_\_\_\_\_

**Parent/Guardian:**

You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the school to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

**School Personnel:** Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+HepB+IPV, Hib+HepB) in each applicable space.

| Type of Vaccine   | DO NOT USE (✓) or (✗) | 1st Dose<br>Mo/Day/Yr | 2nd Dose<br>Mo/Day/Yr | 3rd Dose<br>Mo/Day/Yr | 4th Dose<br>Mo/Day/Yr  | 5th Dose<br>Mo/Day/Yr |
|---|-----------------------|-----------------------|-----------------------|-----------------------|--|-----------------------|
| <b>Required</b> (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)    |                       |                       |                       |                       |  |                       |
| <b>Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)</b><br>• for children age 6 years and younger<br>• final dose on or after age 4 years                           |                       |                       |                       |                       |  |                       |
|   |                       |                       |                       |                       | 5th dose not required if 4rd dose was given on or after the 4th birthday |                       |
| <b>Tetanus and Diphtheria (Td)</b><br>• for children age 7 years and older<br>• 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above |                       |                       |                       |                       |  |                       |
|   |                       |                       |                       |                       |  |                       |
| <b>Tetanus, Diphtheria and Pertussis (Tdap)</b><br>• for children in 7th - 12th grade   |                       |                       |                       |                       |  |                       |
| <b>Polio (IPV, OPV)</b><br>• final dose on or after age 4 years   |                       |                       |                       |                       |  |                       |
|   |                       |                       |                       |                       | 4th dose not required if 3rd dose was given on or after the 4th birthday |                       |
| <b>Measles, Mumps, and Rubella (MMR)</b><br>• minimum age: on or after 1st birthday   |                       |                       |                       |                       |  |                       |
|   |                       |                       |                       |                       |  |                       |
| <b>Hepatitis B (hep B)</b>  |                       |                       |                       |                       |  |                       |
| <b>Varicella (chickenpox)</b><br>• minimum age: on or after 1st birthday<br>• vaccine or disease history required   |                       |                       |                       |                       |  |                       |
|   |                       |                       |                       |                       |  |                       |
| <b>Meningococcal (MCV, MPSV)</b><br>• for children in 7th - 12th grade<br>• booster given at age 16 years   |                       |                       |                       |                       |  |                       |
|   |                       |                       |                       |                       |  |                       |
| <b>Recommended</b>  |                       |                       |                       |                       |  |                       |
| <b>Human Papillomavirus (HPV)</b>   |                       |                       |                       |                       |  |                       |
| <b>Hepatitis A (hep A)</b>  |                       |                       |                       |                       |  |                       |
| <b>Influenza</b> (annually for children 6 months and older)   |                       |                       |                       |                       |  |                       |

**Additional exemptions:**

- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- **Students 18 years of age or older:** Do not need polio vaccine.

**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)

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

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|   |   |
|---|---|
| <p><b>A. Received all required immunizations:</b><br/>I certify that this student has received all immunizations required by law.</p> <p>_____</p> <p>Signature of Parent / Guardian OR Physician / Public Clinic</p> <p>_____ Date</p> | <p><b>B. Will complete required immunizations within the next 8 months:</b></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> <p>_____</p> <p>Signature of Physician / Public Clinic</p> <p>_____ Date</p> |
|---|---|

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

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|   |  |
|---|--|
| <p><b>A. Medical exemption:</b><br/>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:<br/>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> <p>_____</p> <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> <p>_____</p> <p>Signature of physician/nurse practitioner/physician assistant (If disease occurred before September 2010, a parent can sign.)</p> | <p><b>B. Conscientious exemption:</b><br/>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:<br/>I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):</p> <p>_____</p> <p>Signature of parent or legal guardian</p> <p>_____ Date</p> <p>Subscribed and sworn to before me this: _____ day of _____ 20_____</p> <p>_____</p> <p>Signature of notary</p> |
|---|--|

**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