Name: _____
Last Name *First Name* *Middle Name*

DOB: _____ Gender: M F Grade: _____ CIF: _____

Saint Paul Public Schools
A World of Opportunities

6th - 12th Grade Health Examination

Type of Vaccine	1st Dose: MM/DD/YY	2nd Dose: MM/DD/YY	3rd Dose: MM/DD/YY	4th Dose: MM/DD/YY	5th Dose: MM/DD/YY
DPT/DTaP (Diphtheria, Pertussis, Tetanus)					
Td/Tdap (Tetanus, Diphtheria, Pertussis)					
IPV/OPV (Polio)					
MMR (Measles, Mumps, Rubella)					
Hepatitis B (hep B)					
Varicella or history of disease verified by HCP					
Hepatitis A (hep A)					
MCV/MPSV (Meningococcal)					
HIB (Haemophilus Influenza B)					
HPV (Human Papillomas Virus)					
PPSV (Pneumococcal)					

Height: _____ ins. Weight: _____ lbs. Blood Pressure: _____ / _____

Vision: R 20/ _____ L 20/ _____ Corrected: Yes No

Hearing Status: _____ Hearing Aid: Yes No

	500 (25)	1000 (20)	2000 (20)	4000 (20)
Right				
Left				

	Date	Results
Hemoglobin		
Urinalysis		
Tuberculin (PPD)		mm
Chest x-ray		
Blood lead level		

REQUIRED FOR SPORTS:

Any student who intends to participate in interscholastic athletics and/or cheer leading 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			
Inter-school athletics			
Contact sports			
Non-contact sports			

There is a condition that may result in an emergency: Yes No
There is a condition that may interfere with learning: Yes No
(if Yes, elaborate below)

Allergies: _____

Routine Medications: _____

	Normal	Abnormal
Eyes		
cover test		
corneal reflection		
Ears		
Mouth - teeth		
Throat		
Nose		
Lymph nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Hernia		
Genitourinary		
Tanner I II III IV V		
Musculoskeletal		
Spine		
Extremities		
Feet		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Speech		

Please elaborate on any abnormal findings or chronic conditions:

Problem	Assessment	Plan

Note: A separate form is required for all medication and treatment orders.

_____ _____ _____
Signature of Health Care Provider (HCP) *Print Name* *Date of Physical*

_____ ( ) _____
Clinic Name *Phone* *Current Date*

Please return to school Health Office ***OR*** scan and email to student.wellness@spps.org

LEGAL EXEMPTIONS TO MINNESOTA STATUTES 2003, SECTION 121A.15

1. No student under 15 months of age shall be required to be immunized against measles, mumps, and rubella.
2. No student 5 years of age or older shall be required to be immunized against Haemophilus Influenza Type b.
3. No student 7 years of age or older shall be required to be immunized against pertussis.
4. No student 18 years of age or older shall be required to be immunized against poliomyelitis.
5. No student shall be required to receive an immunization for which there is a medical contraindication. The following (or similar) statement must be signed by a physician in order to receive a medical exemption.

I here by certify that immunization is contraindicated for medical reasons for the following immunizations:

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider (HCP) *Date*

6. No student shall be required to receive an immunization for which laboratory evidence of immunity exists.

I hereby certify that laboratory confirmation of the presence of adequate immunity exists for the following immunizations:

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider (HCP) *Date*

7. No student shall be required to receive an immunization which is contrary to the conscientiously held beliefs of the parent or guardian. The following (or similar) statement must be signed and notarized in order for the student to receive an exemption.

I hereby certify by notarization that immunization for my child is contrary to my conscientiously held beliefs. Indicate vaccine(s):

_____

_____

_____

_____

_____ _____

Signature of Parent or Legal Guardian *Date*

Subscribed and sworn to me this _____ day of _____ 20 _____

_____

Signature of Notary

Please return to school Health Office ***OR*** scan and email to student.wellness@spps.org