

Name: _____
Last Name First Name Middle Name

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



- Minnesota law mandates that all children participate in **Early Childhood Screening** prior to Kindergarten entrance.
- The required components are identified with an asterisk (*). For further information, call 651-632-3746.

Preschool - 5th Grade Health Examination

* Type of Vaccine	1 st Dose: MM/DD/YY	2 nd Dose: MM/DD/YY	3 rd Dose: MM/DD/YY	4 th Dose: MM/DD/YY	5 th Dose: MM/DD/YY
DPT/DTap <small>(Diphtheria, Pertussis, Tetanus)</small>					
Td/Tdap <small>(Tetanus, Diphtheria, Pertussis)</small>					
Polio <small>(IPV/OPV)</small>					
MMR <small>(Measles, Mumps, Rubella)</small>					
Hepatitis A					
Hepatitis B					
Varicella					
Meningococcal					
HIB <small>(Haemophilus Influenza B)</small>					
Influenza <small>(Annual)</small>					

Legal Exemptions on Reverse Side

Allergies: _____

Routine Medications: _____

* 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)

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

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

	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		

* Developmental Screening

Approved Screening Tool	Screening Tool Used	Results/Comments
Direct observation using a standardized instrument approved by MN Department of Education (MDE): 1. Parent Report Instruments: <ul style="list-style-type: none"> Ages & Stages Questionnaire (ASQ) Child Development Review Parent Questionnaire (CDR-PQ) Infant Development Inventory (IDI) Parents' Evaluation of Development Status (PEDS) 2. Observational Instruments: <ul style="list-style-type: none"> Brigance Screens Developmental Indicators for Assessment of Learning - 3rd Ed. (DIAL-3) Early Screening Inventory - Revised (ESI-R) Early Screening Profiles FirstSTEP Preschool Screening Tool Minneapolis Preschool Screening Instrument - Revised (MPSI-R) 3. Social/Emotional Screening Instruments: <ul style="list-style-type: none"> Ages & Stages Questionnaire: Social - Emotional (ASQ:SE) Brief Infant Toddler Social Emotional Assessment (BITSEA) Pediatric Symptom Checklist (PSC) 		

Physical ed. restrictions: _____

*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)

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

Print Name

Date of Physical

Clinic Name

Phone

Current Date

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 Physician

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 Physician

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