

**Edina Health Services
Kindergarten – 5th Grade
PHYSICAL EXAM / HEALTH HISTORY**

Name _____ Sex _____ Birth Date _____
 Address _____ Telephone _____
 Father's Name _____ Mother's Name _____

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
Diphtheria, Tetanus, Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT)-for under 7 yrs					
Tetanus and Diphtheria (Td, Tdap)-for 7 yrs and older					
Polio (IPV, OPV)					
MMR (Measles, Mumps, Rubella) (minimum age: on or after 1 st birthday)					
Hepatitis B (Hep B)					
Varicella (chickenpox)					
HIB (Haemophilus Influenza b)					
Other (specify)					

HEALTH HISTORY

Communicable Diseases

- German Measles _____ (month & year)
- Mumps _____ (month & year)
- Red Measles _____ (month & year)
- Chickenpox _____ (month & year)

Identified Health Concerns

No Identified Health Concerns

- ADHD / ADD / other learning disability _____
- Allergies (describe) _____
- Asthma or other breathing problems (describe) _____
- Bladder problems / Bowel problems (describe) _____
- Diabetes: Type 1 Type 2 Managed by: Diet only Oral meds Insulin injections Insulin pump
- Heart Problems (describe) _____
- Seizures: Type (describe) _____
- No Identified Health Concerns

There is a condition that may result in an emergency: yes no (If yes, describe below.)

There is a condition that is being treated with medication: yes no (If yes, describe below.)

There is a condition that may interfere with learning: yes no (If yes, describe below.)

HEALTH EXAMINATION

	DATE	RESULTS
Hemoglobin/Hct		
Urinalysis		
Tuberculin (PPD)		mm
Chest x-ray		
Lead		

	Normal	Abnormal
Ears		
Mouth / Dental		
Throat		
Nose		
Lymph Nodes		
Thyroid		
Heart		
Pulses		
Lungs		
Abdomen		
Musculoskeletal		
Spine		
Extremities		
Skin		
Neurological		
Nutritional Status		
Emotional Status		
Behavior		
Speech		

Height: _____ ins. Weight: _____ lbs. Blood Pressure ____ / ____ Hearing: ___Normal ___Abnormal Hearing aid(s): ___yes ___no Vision: R 20 / ___ L 20 / ___ Corrected ___Yes ___ No

Describe any abnormal findings / chronic conditions.

Health Concerns	Recommendations for School

Note: A separate medication form is required for all medications and treatments to be administered at school.

Signature and title of health care provider Print name Date of physical exam

Clinic name Phone FAX

Please return this form to your school nurse.

The school district intends to use the requested information to provide for your child's health and safety needs while at school. You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health and safety plan for your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success. (MS Section 13.04, Subdivision2)