

Student Health Record: Trinity School at River Ridge

Instructions: Parent/Guardian—please complete Sections A, B, and reverse side.
Physicians—please complete Section D.

Section A

Last name	First name	Middle name	Gender	Birth date

Home Address _____ Home Phone _____
 City _____ State _____ Zip _____ Work Phone _____
 Heads of Household _____ Work Phone _____

Section B—Significant Past Illness History

Allergy (list)	Year	Seizures	Year
Asthma		Serious Injuries (list)	
Chicken Pox		Other Health Problems (list)	
Diabetes			
Hospitalization/Surgery (list reason)			

Section C

Grade	Date	Height	Weight

Vision Screening												
Acuity		Muscle Balance		Color Vision		Corrective Lenses (ck)		Test Used & Comments		Hearing		
R	L	P	F	P	F			<input type="checkbox"/> TITMUS	<input type="checkbox"/> Snellen	<input type="checkbox"/> HOTV	R	L

Comments:

Section D—Physician's Examination: Codes: O - essentially normal X - needs correction C - corrected

Eyes		Endocrine		Musculoskeletal		Gastrointestinal	
Ears		Heart / BP		Neuro		Nutrition	
Nose		Respiratory		Skin/Integument		Urinary	
Throat		Blood		Posture		Reproductive	

Any significant findings/recommendations: _____

Cleared for all sports? Yes No _____

Physician's Signature: _____ Physician's Name (print) _____

Clinic Name and Address _____

Date: _____

Pupil Immunization Record

FOR SCHOOL USE ONLY	
<input type="checkbox"/>	Complete; booster required in _____
<input type="checkbox"/>	In process; 8 mos. expires _____
<input type="checkbox"/>	Medical exemption for _____
<input type="checkbox"/>	Conscientious objection for _____
<input type="checkbox"/>	Parental/guardian consent _____

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.

Parent: Enter the MONTH, DAY, and YEAR for all vaccines your child received, MED for vaccines that are medically contraindicated, or CO for vaccines that are conscientiously opposed. Sign appropriate signature boxes on reverse.

MED: Medical contraindication to immunization, history of disease, or laboratory evidence of immunity.

CO: Immunizations are contrary to parent or guardian's conscientiously held beliefs.

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 Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (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.)						
Diphtheria, Tetanus, and Pertussis (DTaP, DTP)						
Diphtheria and Tetanus (DT) • for 6-year-olds and younger						
Tetanus and Diphtheria (Tdap, Td) • for 7-year-olds and older						
Polio (IPV, OPV)						
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday • required for kindergarten and 7th grade						
Hepatitis B (hep B) • required for kindergarten and 7th grade						
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required for kindergarten and 7th grade						
Recommended						
Meningococcal (MCV, MPSV)						
Human Papillomavirus (HPV)						
Hepatitis A (hep A)						

Additional exemptions:

- **Children less than 7 years of age:** The 5th dose of DTaP/DTP/DT (similarly, the 4th dose of polio vaccine) is not necessary if the 4th DTaP/DTP/DT (3rd dose of polio) was administered after the 4th birthday.
- **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 Td or Tdap booster at age 11 years or later is not required for students in grades 7-12 whose most recent Td was given after their 7th birthday but before their 11th birthday. Instead, it will be required 10 years after the date of the most recent dose.
- **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 10 years or older:** May receive Tdap to fulfill the Td requirement for students in grades 7-12.
- **Students 18 years of age or older:** Do not need polio vaccine.

1. Choose one of the following to indicate student's immunization status and the source of the information above:

A. I certify that this student has received all immunizations required by law.

Signature of parent/guardian or physician/public clinic

Date

B. I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B (K and 7th), varicella (K and 7th), measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months. The dates on which the remaining doses are to be given are:

Signature of physician/public clinic

Date

2. Parental/Guardian Consent to Share Immunization Information:

Your child's school is asking your permission to share your child's immunization record with Minnesota's immunization registry to help us better protect students from disease. 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 record with Minnesota's immunization registry:

Signature of parent or legal guardian

Date

3. Exemptions to School Immunization Law

A. Medical exemption:

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:

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.)

Exempted immunization(s):

Signature of physician/nurse practitioner/physician assistant

Date

*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

Signature of physician/nurse practitioner/physician assistant

B. Conscientious exemption:

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:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

Signature of parent or legal guardian

Date

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

Signature of notary