Independent School District 15

4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

Student Physical Form

Student Name _____ Birth Date _____ School _____ Grade ____ ☐ Male ☐ Female

GENERAL HEALTH STATUS (physical and emotional)**:**

REVIEW OF SYSTEMS

GENERAL	Last dental exam: Allergies:
Head	
EENT	
Cardio-Resp	
GI	
GU	
Musculo-skeletal	
Neurological	
Other	

LABORATORY RESULTS Hgb: U/A: Other:

Height: Weight: Vision: Hearing: B/P:

MEDICATIONS

Medication: Dose: Time(s):

Needed for:

Are medications to be given at school? ☐ Yes ☐ No

Medication: Dose: Time(s):

Needed for:

Are medications to be given at school? ☐ Yes ☐ No

IMMUNIZATIONS List any immunizations given over the past two years: DTaP/DTP _____ (month/day/year) OPV _____ (month/day/year)

Hepatitis B _____ (month/day/year) Hepatitis B _____ (month/day/year) Hepatitis B _____ (month/day/year) Varicella _____ (month/day/year) MMR _____ (month/day/year)

DT _____ (month/day/year) Td/Tdap _____ (month/day/year) MPSV/MCV _____ (month/day/year) HPV _____ (month/day/year) Hepatitis B _____ (month/day/year)

HEALTH CLASSIFICATION FOR SCHOOL ACTIVITIES

☐ Student **IS ABLE** to participate in a regular school program, including all activities in the curriculum (physical education, club activities of an active nature, band, etc.) and also interscholastic athletic activities.

☐ Student **IS NOT ABLE** to participate in a regular school program. The following limitations exist (please specify and give recommendations):

Any explanation to the licensed school nurse in Health Services with reference to items needing medical attention or health habits of the student will be gratefully appreciated. Please note this information on the back of this form.

Date | Signature and Print name of examining health care provider | Telephone Number