

# St. Francis Area Schools

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 \_\_\_\_\_ OPV \_\_\_\_\_  
(month/day/year) (month/day/year)

Hepatitis B \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Varicella \_\_\_\_\_ MMR \_\_\_\_\_  
(month/day/year) (month/day/year) (month/day/year) (month/day/year) (month/day/year)

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