



Dear Parents,

July 2010

My name is Terri Cohn and I am a nurse with the Osseo School District. I provide student health services and assist with health issues at Cedarcrest two days a week. Please feel free to contact me with any communications or questions related to the health of your child, whether it is a communicable disease, illness, injury or a unique health condition. Good communication regarding your child's health will allow us to provide the best environment for them to succeed in the classroom. Please note the following health items requiring your attention prior to school starting.

### **Immunizations**

All students enrolled in Minnesota schools must provide proof of immunization or a notarized legal exemption form to attend school. Documentation of the required immunizations must include month, date and year and be on file **BEFORE** the first day of school. Minnesota law does provide legal exemptions for documented medical reasons or due to the consciously held beliefs of the parents or guardian. Please refer to the Pupil Immunization Record enclosed only to fulfill the above two exemptions allowed by law.

See the attached letter regarding documentation of the **History of Varicella Disease (chickenpox)**. A month and year is needed for proper documentation of the disease.

### **History and Physical**

While a physical examination is not required by State law, we encourage those entering Kindergarten, fourth and seventh grade to have an exam and submit a copy to the health office of this visit.

### **Medications at School**

All prescription and over-the-counter medications that are to be administered at school at any time **MUST** have a Medication Administration Consent Form at school. Please note that this form includes the physician's written order and signature plus the parent/guardian signature. I have attached this form also if needed throughout the year. Students may bring their own cough drops along with a note from home authorizing their use during the school day.

### **Student Emergency Cards**

Please fill out an Emergency Card for each child that is enrolled at Cedarcrest. If any changes occur during the school year please notify the school office immediately. Complete both sides and sign it.

### **Illness**

As much as we love having your children here at school, please keep them home if they are experiencing a contagious disease, vomiting, diarrhea or a temperature greater than 100 degrees in the last 24 hours. Once symptom free (for 24 hours) or cleared by a physician they may return to school

### **Emergency Care Plans**

For any medical condition such as asthma, allergic reactions, diabetes, or any other condition that requires more than basic first aid needs a form at school with parent and physician signatures. Most MDs have their own forms for school purposes. However, if you need a blank form, please contact the school.

Thank you for your cooperation and I look forward to meeting and caring for your children.

Sincerely,

Terri Cohn, RN

Enclosures: History and Physical Form; Medication Administration Consent Form; Emergency Card; Pupil Immunization Record

### HISTORY AND PHYSICAL EXAMINATION FORM

PARENT OR GUARDIAN: Please complete this section prior to seeing physician.

Student's Name: \_\_\_\_\_ Birthdate \_\_\_\_\_  
 (Last) (First) (Initial)

Parent/Guardian \_\_\_\_\_

Grade \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_ School (If Known) \_\_\_\_\_

#### PAST HISTORY

Please CHECK ( 4 ) if your child has ever had -

Red Measles	Other (Specify)	
German Measles	Serious Accident:	
Epilepsy	Surgery (Specify)	
Mumps	Allergies (Specify)	
Asthma	For kindergarten age and under . .	
Heart Disease		
Diabetes	At what age did your child:	
Scarlet Fever	Sit Alone	
Rheumatic Fever	Walk Alone	
Chicken Pox	Talk Words	
High Temperature	Talk Sentences	
Convulsions	Bladder Train	
	Bowel Train	

#### CURRENT HISTORY

Please CHECK ( 4 ) if you have noticed any of these problems recently -

Poor Vision	Frequent Sore Throat
Dizziness	Joint Pains
Fainting Spells	Bladder Problems
Abdominal Pain	Bowel Problems
Allergy	Bleeds Easily
Persistent Cough	Clumsy
Speech Difficulty	Thumb Sucking
Physical Handicap	Asthma
Trouble Sleeping	Tires Easily
Hard of Hearing	Other (Specify)
Shortness of Breath	
Ear Trouble (3 or more times a year)	
Strep Throat (3 or more times a year)	

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PHYSICIAN: Please complete this section**

<b>Tests</b> Indicate: Normal (N) Abnormal (Ab)	Measurements Give Exact Value
If Abnormal include comments below N/Ab	Blood Pressure
	Height
Hemoglobin/Hematocrit	Vision: R20/ L/20
Urine	Hearing: R _____ L _____ w hearing aid Yes No
Other (Specify)	Was standardized developmental screening administered? Yes No Results _____
Ongoing Therapies and Medications - Specify Type and Dose	
Immunizations given at this exam _____	

Examination - Indicate Normal (N) or Abnormal (Ab). If Abnormal include comments below.

	N/Ab		N/Ab
Skin/Lymph		Lungs	
Eyes		Abdomen	
Ears		Genito-urinary	
Nose		Orthopedic-feet	
Mouth		Orthopedic-spine	
Throat		Neurological	
Neck		Speech	
Heart		Other (Specify)	

There is a condition that may result in an Emergency situation.  
 Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, specify \_\_\_\_\_

PROBLEMS AS INDICATED ABOVE \_\_\_\_\_ RECOMMENDATIONS FOR SCHOOL \_\_\_\_\_

#### HEALTH CLASSIFICATION FOR SCHOOL PROGRAM

- Is in excellent health and able to participate in the entire school program.
- There is a condition which may limit participation. (Circle any or all that apply)  
 Classroom Activities Physical Education Competitive Sports (State reason and recommendation above.)  
 Is the above classification temporary? (Circle One) YES NO If YES, state time \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date of Examination \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_  
 (Please Print or Type)

The information requested will be used to provide a background for making educational decisions regarding your child. Although physical exams are not mandated by law, we encourage exams prior to grades K, 4, 7. This information is available to school personnel when necessary in working with your son/daughter. Its use and/or release is subject to ISD 279 policy 5710 and the Minnesota Data Privacy Act.

Osseo Area Schools - Independent School District 279  
**Medication Administration Consent Form**

Name of Student \_\_\_\_\_ Birthdate \_\_\_\_\_ ID # \_\_\_\_\_

School \_\_\_\_\_ School Year \_\_\_\_\_ Grade \_\_\_\_\_

Medical Condition	Medication	Dosage	Time	Route	Possible Side Effects
1.					
2.					
3.					

Other Considerations/Directions \_\_\_\_\_

Start Date \_\_\_\_\_ Stop Date \_\_\_\_\_

\_\_\_\_\_  
 (Print) Name of Physician/Licensed Prescriber

\_\_\_\_\_  
 Signature of Physician/Licensed Prescriber

\_\_\_\_\_  
 Clinic Address

\_\_\_\_\_  
 Phone Number

\_\_\_\_\_  
 Date

**Parent/Guardian Authorization**

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) to be given on field trips, as prescribed.
2. I release school personnel from liability in the event of adverse reactions resulting from taking the medication(s).
3. I will notify the school of any change in the medication(s), (example: dosage change, medication is discontinued, etc.)
4. I give permission for the health specialist to communicate with the student's teachers about the student's health condition and the action of the medication(s).
5. I give permission for the health specialist to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the health specialist.

If there is remaining medication, I give permission for the school to send this home with my child.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/Guardian Signature

\_\_\_\_\_  
 Telephone #

\_\_\_\_\_  
 Relationship to Student

**Note: Medication is to be supplied in the original/prescription bottle.**

**EMERGENCY INFORMATION**

Office Use Only

Student's Legal Name \_\_\_\_\_  
Last Name First Name Middle NameStudent Address \_\_\_\_\_  
Street Apt. No. City Zip Code

Sex \_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_ Teacher (elementary only) \_\_\_\_\_

Student lives with: (1) Both Mother & Father  (2) Father & Stepmother  (3) Mother & Stepfather  (4) Father Only   
(5) Mother Only  (6) Guardian(s)  (7) Foster Parent(s)  (8) Other 

<b>Father's Name</b> (last, first)	Father's Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
		Cell Phone	Pager
		( ) ( )	( ) ( )

<b>Mother's Name</b> (last, first)	Mother's Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
		Cell Phone	Pager
		( ) ( )	( ) ( )

**Other adults living in the household who may provide care for student:**

<b>Name</b> (last, first)	Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
Relationship:		Cell Phone	Pager
		( ) ( )	( ) ( )

<b>Name</b> (last, first)	Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
Relationship:		Cell Phone	Pager
		( ) ( )	( ) ( )

**In case of an emergency and the school staff is unable to reach the parents/guardians listed above, please call:**

Name	Relationship to child	Home Phone	Work Phone
1.		( ) ( )	( ) ( )
2.		( ) ( )	( ) ( )
3.		( ) ( )	( ) ( )

PLEASE COMPLETE BOTH SIDES

5/02

**EMERGENCY INFORMATION**

Office Use Only

Student's Legal Name \_\_\_\_\_  
Last Name First Name Middle NameStudent Address \_\_\_\_\_  
Street Apt. No. City Zip Code

Sex \_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_ Teacher (elementary only) \_\_\_\_\_

Student lives with: (1) Both Mother & Father  (2) Father & Stepmother  (3) Mother & Stepfather  (4) Father Only   
(5) Mother Only  (6) Guardian(s)  (7) Foster Parent(s)  (8) Other 

<b>Father's Name</b> (last, first)	Father's Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
		Cell Phone	Pager
		( ) ( )	( ) ( )

<b>Mother's Name</b> (last, first)	Mother's Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
		Cell Phone	Pager
		( ) ( )	( ) ( )

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<b>Name</b> (last, first)	Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
Relationship:		Cell Phone	Pager
		( ) ( )	( ) ( )

<b>Name</b> (last, first)	Address: (include city, state, zip) <i>(if different from student's address)</i>	Home Phone	Work Phone
		( ) ( )	( ) ( )
Relationship:		Cell Phone	Pager
		( ) ( )	( ) ( )

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3.		( ) ( )	( ) ( )

PLEASE COMPLETE BOTH SIDES

5/02

## Health Information

Student Name \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Family Dentist \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Hospital Preference \_\_\_\_\_

	Yes	No	If yes, please explain	
♦ Chronic health conditions? (heart murmur, asthma, physical handicap, seizures, diabetes, hearing, vision or speech impairment, attention deficit disorder, etc.)				
♦ Illness/injury in past 12 months?				
♦ Is the student taking any medication?				
♦ Asthma inhaler?				
♦ Any restrictions of activities?				
♦ Allergies? (bee stings, food, medications)				
♦ Any immunizations in the past 12 months?			Type:	Mo/Day/Yr.:
Parent/Guardian Signature _____			Type:	Mo/Day/Yr.:

Date \_\_\_\_\_

**If your child will be taking medications/inhalers at school, a Medication Administration Consent Form must be completed by parent/guardian and physician each year. These forms are available from your Health Specialist.**

This information is being collected to provide for the student's health and safety at school and to update our current information. Refusal to supply emergency information could result in the school's inability to contact you in case of an emergency. If unable to reach you or your designee, staff will call 911 for assistance if necessary. Information provided will be shared with school staff having a need to know, unless you indicate otherwise. Updated immunizations are required for the student to attend school. Immunization data is reported to the State, as well as to ImmuLink (Hennepin County immunization registry). Parents may opt out of ImmuLink by calling the health office for further information.

## Health Information

Student Name \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Family Dentist \_\_\_\_\_

Phone (    ) \_\_\_\_\_

Hospital Preference \_\_\_\_\_

	Yes	No	If yes, please explain	
♦ Chronic health conditions? (heart murmur, asthma, physical handicap, seizures, diabetes, hearing, vision or speech impairment, attention deficit disorder, etc.)				
♦ Illness/injury in past 12 months?				
♦ Is the student taking any medication?				
♦ Asthma inhaler?				
♦ Any restrictions of activities?				
♦ Allergies? (bee stings, food, medications)				
♦ Any immunizations in the past 12 months?			Type:	Mo/Day/Yr.:
Parent/Guardian Signature _____			Type:	Mo/Day/Yr.:

Date \_\_\_\_\_

**If your child will be taking medications/inhalers at school, a Medication Administration Consent Form must be completed by parent/guardian and physician each year. These forms are available from your Health Specialist.**

This information is being collected to provide for the student's health and safety at school and to update our current information. Refusal to supply emergency information could result in the school's inability to contact you in case of an emergency. If unable to reach you or your designee, staff will call 911 for assistance if necessary. Information provided will be shared with school staff having a need to know, unless you indicate otherwise. Updated immunizations are required for the student to attend school. Immunization data is reported to the State, as well as to ImmuLink (Hennepin County immunization registry). Parents may opt out of ImmuLink by calling the health office for further information.



# Pupil Immunization Record

FOR SCHOOL USE ONLY

- Complete; booster required in \_\_\_\_\_
- In process; 8 mos. Expires \_\_\_\_\_
- Medical exemption for \_\_\_\_\_
- Conscientious objection for \_\_\_\_\_

Name \_\_\_\_\_ Student Number \_\_\_\_\_

Birthdate \_\_\_\_\_

Minnesota Statutes Section 121A.15 requires children enrolled in a Minnesota school to be immunized against certain diseases, allowing for specified exceptions. This form is designed to provide the school with information required by the law.

Enter the MONTH, DAY, and YEAR for all vaccines the pupil received. DO NOT USE (✓) or (✗).

Vaccines/doses in shaded boxes are recommended but not required by law.

Type of Vaccine	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
Diphtheria, Tetanus, and Pertussis (DTaP, DTP)					
Diphtheria and Tetanus (DT) - formulation for <7 yrs					
Tetanus and Diphtheria (Td, Tdap) - formulation for >7 yrs					
Polio (IPV, OPV)					
Measles, Mumps, and Rubella (MMR) (minimum age: on or after 1 <sup>st</sup> birthday)					
Hepatitis B (hep B)*					
Varicella (chickenpox)**					
Pneumococcal Conjugate (PCV)***					
Haemophilus influenzae type b (Hib)***					
Meningococcal (MPSV4, MCV4)					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Rotavirus					

\* Hepatitis B is required for kindergarten and 7<sup>th</sup> grade.

\*\* Varicella vaccine or disease history is required for kindergarten or 7<sup>th</sup> grade.

\*\*\* PCV and Hib vaccines are recommended only for children through age 4 years.

Note for 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+Hib, Hib+HBV) in each applicable space.

Indicate immunization status and source of above information by choosing one of the following:

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

Signature of parent/guardian or physician/public clinic

Date

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 + 7<sup>th</sup>), varicella (K + 7<sup>th</sup>), 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

**Medical exemption:** No student is required to receive an immunization if they have a medical contraindication or laboratory evidence of immunity. To receive a medical exemption, a physician must sign the following statement:

*I certify that immunization is contraindicated for medical reasons or that laboratory confirmation of adequate immunity exists for the following immunizations:*

Signature of physician

Date

**Conscientious exemption:** No student is required to have an immunization which is contrary to the conscientiously held beliefs of his/her parent or guardian. To receive this exemption, a parent or legal guardian must complete and sign the following statement and have it notarized:

*I 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 before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Signature of notary

### History of varicella disease:

I certify that this child had chickenpox disease on this date: \_\_\_\_\_ (YR) and therefore does not need a varicella shot.

Signature of parent/legal guardian or physician/public clinic

Date

### Additional exemptions

- **Children less than 7 years of age:** The 5<sup>th</sup> dose of DTaP/DTp/DT (similarly, the 4<sup>th</sup> dose of polio vaccine) is not necessary if the 4<sup>th</sup> DTaP/DTp/DT (3<sup>rd</sup> dose of polio) was administered after the 4<sup>th</sup> birthday.
- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTp/DT/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 7<sup>th</sup> birthday but before their 11<sup>th</sup> birthday. Instead, it will be required 10 years after the date of the most recent dose.
- **Students 11-15 years of age:** A 3<sup>rd</sup> dose of hepatitis B vaccine is not required for those 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.

Immunization Program  
P.O. Box 64975  
St. Paul, MN 55164-0975  
651-201-5503 or 1-800-657-3970  
www.health.state.mn.us/immunize  
(12/2007) IC#140-0155