ST. CLOUD AREA SCHOOL DISTRICT 742 ANNUAL PHYSICAL FORM

If your child needs a sports physical, please use the Minnesota State High School League document or have your healthcare provider print the clinic’s sports physical document. Return sports physicals to the school nurse.

Name __________________________________________ Male ________ Female ________ Birthdate ______________
Address __________________________________________________________________________________________ Phone _______________________
Parent/Guardian ____________________________________________________________________________________
Physician/Healthcare Provider _____________________________________________________________________ Dentist ___________________________
Last physical exam ___________________________ Last dental exam ________________________________

**Significant Past History**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>YEAR</th>
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</thead>
<tbody>
<tr>
<td>Allergy (specify)</td>
<td>Mental Health Condition (specify)</td>
</tr>
<tr>
<td>Asthma</td>
<td>Neurologic (specify)</td>
</tr>
<tr>
<td>Chicken Pox (Disease)</td>
<td>Orthopedic (specify)</td>
</tr>
<tr>
<td>Congenital Defect (specify)</td>
<td>Seizure History</td>
</tr>
<tr>
<td>Developmental Delay</td>
<td>Surgeries (specify)</td>
</tr>
<tr>
<td></td>
<td>T&amp;A</td>
</tr>
<tr>
<td></td>
<td>Myringotomy tubes, Hernia</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Vision: Glasses or Contacts</td>
</tr>
<tr>
<td>Hearing</td>
<td>Other</td>
</tr>
<tr>
<td>Heart Condition</td>
<td></td>
</tr>
</tbody>
</table>

**Health Examination**

(To be completed by Physician/Healthcare Provider)

Examining Physician’s/Healthcare Provider’s Name (Print) ________________________________________________________

Ht. __________ Wt. __________ BMI __________ Pulse __________ BP __________ Urinalysis __________ HGB __________

Eyes ___________________________ Orthopedic/Scoliosis ___________________________

Ears ___________________________ Skin ___________________________

Nose ___________________________ Allergies (if so, what?) ___________________________

Throat _________________________ Nutrition ___________________________

Glands _________________________ Serious Illnesses ___________________________

Heart _________________________

Nervous System ___________________________

Please review immunizations and update for school requirements as needed. Please attach copy of immunization record.

Does student require medication on a daily or episodic routine?

Name of medication: ____________________________________________________________

Dose: _______________________________________________________________________

Frequency: __________________________________________________________________

Condition being treated: ____________________________________________________________________________

*Please include a separate physician/healthcare provider’s order if medication will be taken at school.*

Significant Development History __________________________________________________________

History of: Hearing Problem __________________________________________________________

History of: Social or Emotional Problem ________________________________________________

List conditions which may limit participation in:

A. Classroom Activity ________________________________________________________________
B. Physical Education ______________________________________________________________
C. Competitive Sports ______________________________________________________________

***If child is participating in sports, please complete MSHL sports physical form or provide clinic generated document. Any special health problems, recommendations and/or comments __________________________________________________________

**Immunization(s) given today**

Approved for: Full Activity ___________________________ Limited Activity ___________________________

Date ___________________________ Examining Physician/Healthcare Provider Signature ___________________________

I hereby release this information to the Health Services Department of District 742 and give the licensed school nurse permission to clarify the information with the Physician/Healthcare Provider if the need arises.

PARENT/GUARDIAN SIGNATURE ___________________________

NS16.25, Revised 2/4/22