Name:_____

DOB:_____ **Gender:** **M** **F** **Grade:**_____

Academia Cesar Chavez Charter School
1801 Lacrosse Ave
St. Paul, MN 55119
651.778.2940

6th-8th Grade
HEATH EXAMINATION
To be completed by Health Care Provider

Type of Vaccine	1st Dose: MM/DD/YY	2nd Dose: MM/DD/YY	3rd Dose: MM/DD/YY	4th Dose: MM/DD/YY	5th Dose: MM/DD/YY
DPT/Dtap (Diphtheria, Pertussis, Tetanus)					
Td/Tdap (Tetanus, Diphtheria booster)					
IPV/OPV (Polio)					
Hepatitis B (HBV)					
MMR (Measles, Mumps, Rubella)					
Varicella (Chicken Pox)					
MCV/MPSV (Meningococcal)					
HPV (Human Papillomavirus)					
Other: (Specify)					

*shaded immunizations are not required for school

Height:_____ in. Weight: _____lbs. Blood Pressure: _____/_____

Vision: R 20/_____ L 20/_____ Corrected: Y N

Hearing Status: Hearing Aid: Y N

	500 (25)	**1000 (20)**	**2000 (20)**	**4000 (20)**
Right				
Left				

Allergies:_____

Current medications:_____

	Normal	**Abnormal**	**Remarks**
Eye:			
Cover test			
Corneal reflection			
ENT			
Dental			
Heart			
Lungs			
Abdomen			

	Normal	**Abnormal**	**Remarks**
Genitourinary			
Skin			
Extremities			
Musculoskeletal			
Spine / Scoliosis			
Nutrition status			
Emotional Status			
Speech			

Required for Sports:	**Permitted**	**Restricted**	**Restricted Activity**
Physical Ed. Class			
Inter-school athletics			
Contact Sports			
Non-contact sports			

There is a condition that may result in an emergency: Y N
There is a condition that may interfere with learning: Y N
(If yes, elaborate below)

Health Concern	Medication/Treatment/Referral Plan	Recommendations for School

_____ _____ _____
Signature of Health Care Provider | Print Name | Date of Physical

_____ _____ _____
Clinic Name | Phone | Current Date