



CERTIFICATE OF IMMUNIZATION
NORTH DAKOTA DEPARTMENT OF HEALTH
 SFN 16038 (Revised 01-2018)

Division of Disease Control
 2635 East Main Ave. PO Box 5520
 Bismarck, ND 58506-5520
 800.472.2180 or 701.328.3386

Child's Name (Last, First, Middle Initial):	Date of Birth:
Parent's Name:	Telephone Number:

Vaccine Type		Exemption Type*	Enter Month/Day/Year for Each Immunization Given			
Hepatitis B	Hepatitis B					
Rotavirus	Rotavirus					
Hib	<i>Haemophilus influenzae</i> type B					
PCV	Pneumococcal conjugate					
DTP/DTaP/DT	Diphtheria-Tetanus-Pertussis					
IPV/OPV	Polio					
MMR	Measles-Mumps-Rubella					
Varicella	Chickenpox					
Hepatitis A	Hepatitis A					
Td/Tdap	Tetanus-Diphtheria (and Pertussis)					
MCV4	Meningococcal ACYW-135					
HPV	Human Papillomavirus					
Men B	Meningococcal B					
Other						

To the best of my knowledge, this person has received the above-indicated immunizations on the above dates.

Physician, Nurse, Local/State Health:	Title:	Date:
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If additional doses are added after initial signature, please initial dose and sign below.

Update signature #1:

Physician, Nurse, Local/State Health:	Title:	Date:
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Update signature #2:

Physician, Nurse, Local/State Health:	Title:	Date:
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My child has not met the minimum requirements for his/her age. I agree to resume immunizations within 30 days from the date I was notified (today's date noted below) and to submit a signed Certificate of Immunization.

Parent/Guardian Signature:	Date:
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Statement of Exemption to Immunization Law

In the event of an outbreak, exempted persons may be subject to exclusion from school or childcare facility.

Medical (Med) Exemption: (Indicate vaccine above, requires physician signature) The physical condition of the above-named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

History of Disease (HD) Exemption: (Indicate vaccine above, requires physician signature) To the best of my knowledge, the above named person has had prior infection as indicated by prior diagnosis or laboratory confirmation.

Physician Signature:	Date:
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Religious (Rel), Philosophical/Moral (PBE) Exemption: (Indicate vaccine above, requires parental signature)

Parent/Guardian Signature:	Date:
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* Medical =Med, History of Disease = HD, Religious = Rel, Philosophical/Moral = PBE

2018 – 2019 School Immunization Requirements

Vaccine Type	Number of Required Doses		
	Kindergarten-6 th grade	Grades 7-10	Grades 11-12
DTaP/DTP/DT/Tdap/Td*	5	5	5
Hepatitis B	3	3	3
IPV/OPV [†]	4	4	4
MMR	2	2	2
Varicella (Chickenpox)	2	2	1
Meningococcal [¶]	0	1	2
Tdap [⊖]	0	1	1

* One dose of DTaP (pediatric diphtheria, tetanus, and acellular pertussis) vaccine must have been given on or after the fourth birthday. Only four doses are necessary if the fourth dose was administered on or after the fourth birthday. Three doses of Tdap (adolescent/adult tetanus, diphtheria, and acellular pertussis)/Td are required for children ages seven or older who were not previously vaccinated. Tdap should be used as the first dose followed by two doses of Td for children age seven or older not previously vaccinated.

† For polio vaccination, in all-IPV or all-OPV schedule: one dose must have been given on or after the fourth birthday. The final dose in the series should be administered on or after the fourth birthday and at least six months after the previous dose. If four doses are administered prior to age four, a fifth dose should be administered on or after age four. Only three doses of IPV are required if the third dose is given on or after the fourth birthday. Children born before August 2005 only need four doses separated by at least four weeks. These children do not need a dose after the age of four.

¶ One dose of meningococcal conjugate vaccine (MCV4) must have been given on or after the tenth birthday. The second dose of MCV4 must be given on or after the sixteenth birthday. If the first dose of MCV4 is given after the sixteenth birthday, then only one dose of MCV4 is required for eleventh and twelfth grade.

⊖ One dose of Tdap must have been given on or after the seventh birthday.

Exemptions

Students may be exempt from immunization requirements for the following reasons:

- **Medical Exemption:** Requires a certificate signed by a licensed physician stating that the physical condition of the child is such that immunization would endanger the life or health of the child.
- **Personal Belief or Religious Belief Exemption:** Requires a certificate signed by the parent or guardian whose sincerely held philosophical, moral or religious belief is opposed to such immunization.
- **History of Disease Exemption:** Requires a certificate signed by a physician stating that the child has a reliable history of disease. History of disease exemptions may only be claimed for hepatitis B, varicella, measles, mumps, or rubella.

Exclusion

All children need to be up-to-date according to the school immunization requirements or have claimed an exemption by **October 1st** of each school year or they must be excluded from school. Children enrolling in school after October 1st have 30 days to be up-to-date or claim an exemption or they must be excluded from school.

NDHSAA Preparticipation Physical Evaluation Form

Starting with the 2010-11 school year, student athletes participating in NDHSAA sanctioned sports programs will be required to file a pre-participation health history screening and physical examination clearance form (page 4) with their school office prior to their participation on a yearly basis. As per NDHSAA Constitution and By-Laws, physical evaluations may be done by the following medical professionals: Medical Doctor, Doctor of Osteopathy, Physicians Assistant, Nurse Practitioner (MD, DO, PA, NP); the Athletic Pre-Participation Health History Screening and Physical Examination is valid for one school year; a physical examination must be completed on or after * **April 15** to be valid for participation the following school year.

*** Date amended by membership - October 2010**

The NDHSAA approved form explanations appear below:

History Form Page 1

To be filled out by Parent/Athlete prior to physical evaluation
The medical facility should keep this form.

Special Needs Supplemental History Form Page 2

Filled out **ONLY** if athlete is special needs.
The medical facility should keep this form.

Physical Examination Form Page 3

Completed by medical personnel and retained in medical facility file
The medical facility should keep this form.

Clearance Form Page 4

This is the **ONLY** form that should be returned to the school office.

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM - Parent/Athlete fill out prior to physical evaluation

Revised: June 2010
Page 1

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

NDHSAA PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM - Complete **ONLY IF special needs athletes.**
The medical facility should keep this form.

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Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PHYSICAL EXAMINATION FORM - The medical facility should keep this form.

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of MD, DO, PA, NP (print/type) _____ Date _____
 Address _____ Phone _____
 Signature of MD, DO, PA, NP _____, MD or DO

**NDHSAA PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM - Return this page ONLY to school office**

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Name _____ Sex M F Age _____ Date of Birth _____ Grade _____

- Cleared for all sports without restriction
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of MD, DO, PA, NP (print/type) _____ Date _____
Address _____ Phone _____
Signature of MD, DO, PA, NP _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other Information _____

PERMISSION FOR MEDICAL TREATMENT

In the event of an emergency requiring medical attention, I hereby grant permission for emergency treatment for my daughter/son. I expect an effort will be made to contact me if an emergency occurs. I understand the cost for any medical attention may not be covered or paid by any high school or the North Dakota High School Activities Association. I hereby approve participation in athletic activities.

Grade of Athlete _____ School _____ Sport(s) _____

Parent/Guardian Signature _____ Date _____