

HEALTH EXAMINATION CARD

Last Name _____ First Name _____ Birthdate _____ (M) (F) (W) (B) (H) (A) (Other) _____
 Address _____ Phone _____ School _____ Grade _____
 Parent or Guardian's Name _____ Name of Physician _____

The Nebraska School Immunization Rules and Regulations require students to provide proof of immunization before attending school.

PLEASE WRITE MONTH, DAY, YEAR IMMUNIZATIONS WERE GIVEN BELOW:

Immunization	(Month/Day/Year)	Immunization	(Month/Day/Year)	Immunization	(Month/Day/Year)
DTP/Td	1. / /	Polio (oral)	1. / /	Hepatitis B (Hep B)	1. / /
	2. / /		2. / /		2. / /
	3. / /		3. / /		3. / /
	4. / /	MMR 1	4. / /	Varcella 1	1. / /
	5. / /		1. / /		2. / /
Tdap	1. / /	MMR 2	2. / /	Other	/ /
Other	/ /	Other	/ /	Other	/ /

PHYSICAL EXAM: Blood Pressure _____ / _____ Pulse _____ Respirations _____
 General Appearance _____ Height _____ Weight _____ BMI _____ BMI% _____
 Nutritional Status _____ Hematocrit or Hgb. _____ Urinalysis _____
 Skeletal Development/Posture _____ Scoliosis _____
 Scalp and Skin _____ Lymph Nodes _____ Neck _____
 Ears _____ Nose _____ Throat _____
 Mouth _____ Teeth and Gums _____ Speech _____
 Heart _____
 Lungs _____ Tuberculin Skin Test: Positive _____ Negative _____
 Abdominal Examination _____ Hernia _____
 Extremities - Upper _____ Extremities - Lower _____
 Neurological exam _____
 Mental developmental assessment _____

Vision Exam required for Kindergarten and students transferring from outside of NE (Please document all tests listed below).			
Tests	Pass	Fail	Recommend Further Examinations (See comments below)
Amblyopia			
Strabismus			
Internal Eye Health			
External Eye Health			
Visual Acuity	Right	Left	Both
With/without Glasses	20/	20/	20/

HEALTH HISTORY: Check any past or present illness of this child the school should be made aware of, such as:

asthma concussion physical handicaps
 allergies diabetes seizure disorder
 cancer heart disease serious injuries
 chicken pox kidney infections surgical operations
 Other (specify): _____

Hearing Screening:	Pass			Fail		
AUDIO TEST	500	1000	2000	4000	6000	8000
Right Ear						
Left Ear						

- Is this child subject to any illness which may result in a classroom emergency? YES () NO ()
If yes, please describe: _____
- Is this child subject to any condition which limits: Classroom activities? YES () NO ()
Physical education? YES () NO ()
Competitive sports? YES () NO ()
If yes, please describe: _____
- Is this child taking any medication? YES () NO () If yes, please identify, etc.: _____
- Any other remarks or suggestions? _____

Date of exam _____

Signature of Health Care Provider _____

Phone _____