HEALTH EXAMINATION CARD

Last Name _____ First Name _____ Birthdate _____ (M) (F) (W) (B) (H) (A) (Other) Circle Race _____

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. / /		4. / /	Varcella 1	1. / /
	5. / /	MMR 1	1. / /	Varcella 2	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 With/without Glasses	Right 20/	Left 20/	Both 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						

1. Is this child subject to any illness which may result in a classroom emergency? YES ( ) NO ( )
   If yes, please describe: _____
2. 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: _____
3. Is this child taking any medication? YES ( ) NO ( ) If yes, please identify, etc.: _____
4. Any other remarks or suggestions? _____

_____ Date of exam

_____ Signature of Health Care Provider

Phone _____