

HEALTH EXAMINATION CARD

7th Grade

DENTAL EXAM DATE

(M) (F) (W) (B) (Other)
 Sex Circle Race

Last Name First Name Birthdate Sex 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 (Diphtheria Tetanus-Pertussis)	1. / /	POLIO	1. / /	M-M-R 1	/ / /	
	2. / /		2. / /	M-M-R 2	/ / /	
	3. / /		3. / /	Varicella 1	/ / /	
	4. / /		4. / /	Varicella 2	/ / /	
	5. / /	HIB	1. / /	3. / /	Other	/ / /
	6. / /		2. / /	4. / /		

Hep B 1. / / 2. / / 3. / / Hep B (2 Dose Series, ages 11-15) 1. / / 2. / /

PHYSICAL EXAM: Blood Pressure / Pulse / Respirations /

General Appearance / Height / Weight /

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 development assessment /

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

asthma hepatitis
 allergies kidney infections
 cancer physical handicaps
 chicken pox seizure disorder
 diabetes serious injuries
 heart disease surgical operations

Other (specify): _____

VISION SCREENING:		Pass	Fail			
Without Correction		With Correction				
Right eye 20/		Right eye 20/				
Left eye 20/		Left eye 20/				
Both eyes 20/		Both eyes 20/				
Amblyopia		Strabismus				
Internal Eye Health						
External Eye Health						
HEARING SCREENING:		Pass	Fail			
AUDIO TEST	500	1000	2000	4000	6000	8000
Right ear						
Left ear						
IMPEDANCE:		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 _____ [] CU [] HDC
 [] UNMC [] Private M.D. Signature of Licensed Medical Doctor
 Phone _____