

HEALTH EXAMINATION CARD

DENTAL EXAM DATE

____/____/____

7th Grade

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

Last Name _____ First Name _____ Birthdate _____ Sex _____ 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 _____

HS 135 (OVER) Forms Associates, Inc.

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