

HEALTH EXAMINATION CARD

DENTAL EXAM DATE

____/____/____

Kindergarten and Out-of-State Transfer Students

Last Name _____ First Name _____ Birth Date _____ (M) (F) (W) (B) (Other)
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 1.	____/____/____	Polio	1. ____/____/____	M-M-R	1. ____/____/____
Tetanus-Pertussis) 2.	____/____/____		2. ____/____/____	M-M-R	2. ____/____/____
3.	____/____/____		3. ____/____/____		
4.	____/____/____		4. ____/____/____		
5.	____/____/____				
6.	____/____/____	HIB 1.	____/____/____	3. ____/____/____	Varicella 1. ____/____/____
		2.	____/____/____	4. ____/____/____	Varicella 2. ____/____/____
Hep B 1.	____/____/____	2.	____/____/____	3.	____/____/____
Hep B (2 Dose Series, ages 11-15) 1.	____/____/____	2.	____/____/____	Other	____/____/____

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 _____
 Eyes _____ 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 health condition that school should be made aware of, such as:

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

VISION EVALUATION--COMPLETE FORM ON BACK						
HEARING SCREENING:		NORMAL			ABNORMAL	
Audio Test	500	1000	2000	4000	6000	8000
Right Ear						
Left Ear						
IMPEDANCE:		Right Ear		Left Ear		

- Other (specify): _____
- Is this child subject to any health condition that may result in a classroom emergency? YES () NO ()
If yes, please describe: _____
 - Is this child subject to any condition that 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 Licensed Health Care Provider _____ [] M.D. [] P.A. [] A.P.R.N [] O.D Phone _____

**VISITING NURSE ASSOCIATION
School Health Program**

Vision Evaluation Form

Nebraska State Law requires all students entering the beginner grade or transferring from an out-of-state school to provide proof of a **vision evaluation** within six (6) months prior to school entrance. The vision evaluation performed by a physician, physician assistant, advanced practice registered nurse or optometrist **shall include testing for amblyopia, strabismus, internal and external eye health and visual acuity**. Exception to the requirement may be made if the parent / guardian submits a written statement refusing the vision evaluation.

Student _____ Evaluation Date _____

RESULTS:	Negative	Positive	Further Recommendations (see comments below)
Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____
	Normal	Abnormal	
Internal Eye Health	_____	_____	_____
External Eye Health	_____	_____	_____
Visual Acuity	Right: 20/ _____	Left: 20/ _____	Both: 20/ _____
	_____ without correction	_____ with correction	

Comments/Recommendations _____

Signature of Health Care Provider **Date**

Please check provider type: _____ M.D. _____ O.D. _____ P.A. _____ A.P.R.N.