HEALTH EXAMINATION CARD

Kindergarten and Out-of-State Transfer Students

DENTAL EXAM DATE ____/____/____

Last Name _____ First Name _____ Birth Date _____ (M) (F) Sex _____ (W) (B) (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(Diptheria Tetanus-Pertussis)	1.___/___/___ 2.___/___/___ 3.___/___/___ 4.___/___/___ 5.___/___/___ 6.___/___/___	Polio	1.___/___/___ 2.___/___/___ 3.___/___/___ 4.___/___/___	M-M-R M-M-R	1.___/___/___ 2.___/___/___
		HIB	1.___/___/___ 3.___/___/___ 2.___/___/___ 4.___/___/___	Varicella Varicella	1.___/___/___ 2.___/___/___
Hep B	1.___/___/___ 2.___/___/___ 3.___/___/___			Other	___/___/___
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 _____

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

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		

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

1/08 ***PLEASE SEE BACK OF FORM TO RECORD STATE REQUIRED VISION EVALUATION***

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.

1/07