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
- ____ allergies
- ____ cancer
- ____ chicken pox
- ____ concussion
- ____ diabetes
- ____ heart disease
- ____ kidney infections
- ____ physical handicaps
- ____ seizure disorder
- ____ serious injuries
- ____ 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 ______

SCHOOL VISION EVALUATION
Report Form

A ***School Vision Evaluation*** **is required** for all children **within six months prior to entering** Nebraska schools for the first time *(includes beginner grades including Kindergarteners, transfers, and other students new to Nebraska)* [Nebraska Revised Statute 79-214]

Name: ______________________ Date of Birth: ______________

School: ______________________ Date: ______________

Student Status (*check one*): ____ Beginner Grade ____ Transfer Student from Out of State

REQUIRED TESTS*		Pass	Fail	Recommend Further Evaluation *(comments noted below)*
Amblyopia		____	____	____
Strabismus		____	____	____
Internal Eye Health		____	____	____
External Eye Health		____	____	____
Visual Acuity				
	Right eye @ distance (20 ft.):		20/____	aided/unaided
	Left eye @ distance (20 ft.):		20/____	aided/unaided
	Right eye @ near (16 in.):		20/____	aided/unaided
	Left eye @ near (16 in.):		20/____	aided/unaided

**A vision evaluation consisting of these required tests meets the legal requirements for the State of Nebraska but is not a complete eye examination such as most eye doctors perform.*

ADDITIONAL TESTS	Pass	Fail	Recommend Further Evaluation
Eye Alignment at Distance	____	____	____
Eye Alignment at Near	____	____	____
Depth Perception	____	____	____
Color Vision	____	____	____
Focusing Amount	____	____	____
Focusing Flexibility	____	____	____
Focusing Lag (Accuracy)	____	____	____
Convergence (Crossing) Ability	____	____	____
Saccade (Rapid) Eye Movement	____	____	____
Pursuit (Tracking) Eye Movement	____	____	____
Other: ____________	____	____	____

COMMENTS/RECOMMENDATIONS: ______________________________

____

____

Evaluation performed by: ______________________ **Date:** ______________

(signature)

____O.D. ____M.D. ____P.A. ____A.P.R.N.

Original—Doctor Copy #1—Parent Copy #2—School Nurse Copy #3—Placed in student's permanent file