OMAHA PUBLIC SCHOOLS
HEALTH EXAMINATION CARD

Last Name ___________________ First Name ________________ Birthday______ Gender: M___ F___
Address _____________________________ Phone ____________ School ___________ Grade ______
Parent or Guardian's Name ____
Name of Health Care Provider ____

IMMUNIZATIONS (obtain a copy of the immunization record if possible)

Immunization	Month/Day/Year	**Immunization**	Month/Day/Year	**Immunization**	Month/Day/Year
DTaP 1	____/____/____	Polio 1	____/____/____	HEP B 1	____/____/____
2	____/____/____	2	____/____/____	2	____/____/____
3	____/____/____	3	____/____/____	3	____/____/____
4	____/____/____	4	____/____/____	4	____/____/____
5	____/____/____	5	____/____/____		
				HEP B 1	____/____/____
Td 1	____/____/____	MMR 1	____/____/____	(2-dose series) 2	____/____/____
2	____/____/____	2	____/____/____		
3	____/____/____			HEP A 1	____/____/____
		HIB 1	____/____/____	2	____/____/____
Tdap 1	____/____/____	2	____/____/____		
2	____/____/____	3	____/____/____	TB skin test	Result
		4	____/____/____	____/____/____	________
VZV 1	____/____/____	Prevnar 1	____/____/____	____/____/____	________
2	____/____/____	2	____/____/____		
Date parent reported disease	________	3	____/____/____	Influenza	____/____/____
		4	____/____/____		____/____/____
HPV 1	____/____/____				____/____/____
2	____/____/____	Meningococcal	____/____/____	Other	________________
3	____/____/____				________________

HEALTH HISTORY

______ Fainting ______ Head Injury ______ Asthma
______ Seizure ______ Surgery ______ Allergies
______Other, describe ____
______ Family history of sudden death prior to age 50 ______________________________

PHYSICAL EXAMINATION

General Appearance ______________________Height _______ Weight ___________ BMI _______
Lab: HCT or HGB ____________________ Lead level drawn _________Yes ___ No ___ BP________
Skeletal Development _________________________Posture __________ Scoliosis _____________
Hair/Skin____________________________ Lymph _____________Head/Neck ________________
Ears ___________________ Nose/Sinus ________________ Throat __________________________
Mouth___________________ Dental______________________ Speech ______________________
Heart ___________________________ Rhythm ________ Rate _______ Chest/Lungs _____________

(over)

Abdomen ____Back __________________________
Extremities ____
Neurological Exam ____
Mental development assessment ____
Medical diagnosis ____
Is this child subject to any condition limiting classroom or physical activities? ___ No ___ Yes
If "Yes", describe ____
Is this child taking any medication? ___No ___Yes if "Yes", list medications _____________________
____
List concerns/remarks ____
____

HEARING SCREENING: _______Pass _____Fail Referral_______________________

Audio Test	500Hz	1000Hz	2000Hz	4000Hz
Right Ear---dB	_________	______	______	______
Left Ear ----dB	_________	______	______	______

VISION EXAM required for Kindergarten and students transferring from outside of NE

Tests	Pass	Fail	Recommend Further Examination (See Comments Below)
Amblyopia	____	____	_____
Strabismus	____	____	_____
Internal Eye Health	____	____	_____
External Eye Health	____	____	_____

Visual Acuity Right 20/_____ Left 20/_____with/without glasses

Comments/Recommendations/Restrictions____
____
____

____________	______________________________________	_____________
Date of PE	Signature of Licensed Health Care Provider	Office Phone #