

**OMAHA PUBLIC SCHOOLS**  
**HEALTH EXAMINATION CARD**

Side 1 of 2

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	____/____/____		
Td 1	____/____/____	MMR 1	____/____/____	HEP B	1 ____/____/____
2	____/____/____	2	____/____/____	(2-dose series) 2	____/____/____
3	____/____/____			HEP A	1 ____/____/____
		HIB 1	____/____/____	2	____/____/____
Tdap 1	____/____/____	2	____/____/____		
2	____/____/____	3	____/____/____	TB skin test	Result
		4	____/____/____	____/____/____	_____
VZV 1	____/____/____	Pevnar 1	____/____/____	____/____/____	_____
2	____/____/____	2	____/____/____		
Date parent reported disease	_____	3	____/____/____	Influenza	____/____/____
		4	____/____/____	____/____/____	_____
HPV 1	____/____/____	Meningococcal	____/____/____	Other	_____
2	____/____/____			_____	_____
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

**Comment/Recommendations** \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Date of PE

\_\_\_\_\_  
 Signature of Licensed Health Care Provider

\_\_\_\_\_  
 Office Phone #