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 _____/_____/_____
2 _____/_____/_____
3 _____/_____/_____
4 _____/_____/_____
5 _____/_____/_____

Td 1 _____/_____/_____
2 _____/_____/_____
3 _____/_____/_____

Tdap 1 _____/_____/_____
2 _____/_____/_____

Polio 1 ___/_____/_____
2 ___/_____/_____
3 ___/_____/_____
4 ___/_____/_____
5 ___/_____/_____

MMR 1 ___/_____/_____
2 ___/_____/_____

HIB 1 ___/_____/_____
2 ___/_____/_____
3 ___/_____/_____
4 ___/_____/_____

VZV 1____/___/_____
2____/___/_____

Date parent reported disease_____

HPV 1____/___/____
2____/___/____
3____/___/____

Prevnar 1____/___/_____
2____/___/_____
3____/___/_____
4____/___/_____

Meningococcal ___/___/_____

HEP B 1 ____/_____/_____
2 ____/_____/_____
3 ____/_____/_____
4 ____/_____/_____

HEP B 1 ____/_____/_____
(2-dose series) 2 ____/_____/_____

HEP A 1 ___/_____/_____
2 ___/_____/_____

TB skin test Result
___/_____/_____ _____

___/_____/_____ _____

Influenza ____/____/_____
____/___/_____
____/___/_____

Other _____
_____

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 #