HEALTH EXAMINATION CARD ~ ST. JOAN OF ARC CATHOLIC SCHOOL

Last Name First Name Birthdate Sex Ethic Origin

Address Phone School Grade

Parent/Guardian Name Name of Physician

The Nebraska School Immunization Rules and Regulations effective July 2000, require additional immunizations for children entering **kindergarten**, 7th grade, or transfer students from out of state. Student must provide proof of immunizations before attending school.

IMMUNIZATION RECORD

Vaccine Type — Date of Each Dose: (Enter date when each immunization was given)

Vaccine Type	1	2	3	4	5
DPT/DTaP/Td					
Polio, OPV, IPV					
Hib,Haemophilus, Influenzae b					
Hepatitis B					
PCV, Pneumococcal					
MMR					
Varicella					

Physical Exam:

Blood Pressure: ______ Pulse: ______ Respiration: ______
General Appearance: ______ Height: ______ Weight: ______
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: ______ Lower: ______
Neurological Exam: ______
Mental Development Assessment ______

HEALTH HISTORY: Check any past or present illness of this child the school should be made aware of:

Asthma: ______ Allergies: ______ Cancer: ______
Chicken Pox: ______ Diabetes: ______ Heart Disease: ______
Hepatitis: ______ Kidney Infections: ______ Physical Handicaps: ______
Seizure Disorder: ______ Serious Injuries: ______ Surgical Operations: ______
Other: ______

1. Is this child subject to any illness which may result in a classroom Emergency? Yes ______ No ______
If yes, please describe: ______

2. If this child subject to any condition with limits: Classroom Activities? Yes ______ No ______
Physical Educations? Yes ______ No ______
Competitive Sports? Yes ______ No ______
If yes, please describe: ______

3. Is this child taking any medication: Yes ______ No ______ If yes, please identify: ______

4. Any other remarks or suggestions: ______

Date of Exam ______ Phone ______ Signature of Licensed Medical Doctor ______ ( ) CU ( ) UNMC ( ) Private M.D. ( ) Other ______

DENTAL EXAM Remarks: ______

Date of Exam ______ Phone ______ Signature of Licensed Dentist ______