St. Vincent de Paul School
14330 Eagle Run Drive
Omaha NE. 68164
402.492.2111 phone
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Health exam must be done *after* March 1st of current year and is due August 1st

HEALTH EXAMINATION FORM

Dental Exam Date _____

Name: _____ Date of Birth: _____ Sex: M F Grade: _____

Address: _____ Phone: _____

Parent or Guardian's Name: _____ Name of Physician: _____

Nebraska Law (Section 79-214 & 79-217) states that all students in grades K-12 are to be protected against measles, mumps, rubella, diphtheria, tetanus, pertussis, and polio before attending school. School law also requires physical examinations at the time of school entry, at seventh grade and for all transfer students. Exceptions may be made only if the parent or guardian submits a written statement informing the school they do not wish their child to be immunized or to have a physical examination.

Immunizations (Please write Month/Day/Year

DTP/Td	**1.**	**Polio**	**1.**	**HepB**	**1.**	**Hib**	**1.**	**PCV7**	**1.**	**Other:**	
	2.		**2.**		**2.**		**2.**		**2.**		
	3.		**3.**		**3.**		**3.**		**3.**		
	4.		**4.**	**MMR**	**1.**		**4.**		**4.**		
	5.	**Varicella**	**1.**		**2.**	**HepA**	**1.**	**PCV13**	**1.**		
Tdap	**1.**		**2.**	**MCV4**	**1.**		**2.**				

PHYSICAL EXAM

Blood Pressure _____ Pulse _____Respirations _____

General Appearance _____ Height _____ Weight _____ BMI_____

Nutritional Status _____ Hematocrit/Hgb _____ Urinalysis _____

Skeletal Development/Posture _____ Scoliosis _____ Tuberculin Skin Test: Positive Negative

Scalp and Skin _____ Lymph Nodes _____ Neck _____

Ears _____ Nose _____ Throat _____

Mouth _____ Teeth and Gums _____ Speech _____

Heart _____ Lungs _____

Abdomen _____ Hernia _____

Upper Extremities _____ Lower Extremities _____

Neurological exam _____ Mental development assessment _____

VISION SCREENING:

			Recommended Further Evaluation
Amblyopia	Pass	Fail	_____
Strabismus	Pass	Fail	_____
Internal Eye Health	Pass	Fail	_____
External Eye Health	Pass	Fail	_____

Visual Acuity

Right eye @ distance (20 ft.)	20/_____	aided / unaided
Left eye @ distance (20 ft.)	20/_____	aided / unaided
Both @ distance (20ft)	20/_____	aided / unaided

HEARING SCREENING: Pass Fail

Audio Test:	500	1000	2000	4000	6000	8000
Right ear	_____	_____	_____	_____	____	____
Left ear	_____	_____	_____	_____	____	____

Comments/Recommendations _____

Impedance: Right ear _____Left ear _____

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

_____ asthma	_____ hepatitis	Other (specify): _____
_____ allergies	_____ kidney infections	
_____ cancer	_____ physical handicaps	
_____ chicken pox	_____ seizure disorder	
_____ diabetes	_____ serious injuries	
_____ heart disease	_____ surgical operations	

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 suggestion? _____

Date of Exam: _____ Signature of Licensed Medical Doctor: _____ Phone_____

Revised 12/13/17