STUDENT HEALTH EXAMINATION CARD School: St. Mary's Catholic School, Bellevue, NE Grade: K/7th

Name (Last, First, MI): ______________________________ Birthdate: _____________ Male / Female

Parent/Guardian's Name: _________________________ Phone (H): 402_________ (W): 402___________

Address: _______________________________________ Physician: ______________________________________

DtaP		Td/Tdap	Polio		MMR	
Date			Date		Date	
Date			Date		Date	
Date			Date		MMR-V	
Date			Date		Date	
Date			Date		Date	
Hepatitis A			Menactra		Varicella (Chicken Pox)	
Date			Date		Date	
Date			Date		Date	
Hepatitis B			Other		OR Date of Chicken pox disease	
					Date	12/2004

Physical Examination: General Appearance: ______________________________ Ht: ____________ Wt: ______________

Nutritional Status: _______________________________ Hematocrit or Hgb: ___________ Urinalysis: ________________

Skeleton Development: __________________________ Posture: ____________________ Scoliosis: __________________

Scalp & Skin: ___________________ Lymph Nodes: _____________________ Neck: ______________________________

Ears: ___________________ Nose: _______________________ Throat: ________________ Mouth: ________________

Teeth & Gums: ___________________ Speech: ________________________

B/P: _______/_________ Pulse: ________ Respirations: _____________ Heart: ___________ Lungs: ______________

TB Skin Test: Positive _______________ Negative _______________

Abdominal Exam: ________ ___________________________ Hernias: _______________________________

Upper Extremities: ___________________________________ Lower Extremities: _______________________

Neurological Exam: ____

Mental Development Assessment: ____

Health History: check any past or present illness of this child the school should be made aware of, such as:	Vision Screening: Pass Fail			
__Allergies __Asthma __Cancer __Diabetes __ Epilepsy __Heart Disease __Kidney Infections __Chicken Pox __Serious Injuries __Hepatitis __Seizure Disorder __Physical Handicaps: __Other __Other __Other	W/O Correction 20 ft	W/O Correction 16 in	With Correction 20 ft	With Correction 16 in
	R Eye 20 / ___	R Eye 20 / ___	R Eye 20 / ___	R Eye 20 / ___
	L Eye 20 / ___	L Eye 20 / ___	L Eye 20 / ___	L Eye 20 / ___
	KG/Out of state transfer vision Exam			
Hearing Screen: Pass Fail Audio 500 1000 2000 4000 6000 R Ear______________________________ L Ear ______________________________	Pass Fail Amblyopia ______ ________ Strabismus ______ ________ Internal Eye Health ______ ________ External Eye Health ______ ________			

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 medications? ___Yes ___No If yes, please describe: __________________________

Date of Exam: __________ MD's Phone #: 402-____-_______ MD/PA/NP Signature: __________________________