St. Wenceslaus School
PHYSICIAN EXAM
HEALTH FORM GUIDELINES

Students entering school for the first time (K **or** 1st Grade) and students entering 7th Grade and transfer students from outside the State of Nebraska, regardless of grade (includes any foreign students) are required to have the following immunizations with records. The students are also required to have an eye exam and all fields in the form completed.

*1 dose of varicella (chickenpox) or MMRV if given on or after 12 months of age and prior to 13 years of age. If given at over 13 years of age, 2 doses of varicella (no MMRV), separated by at least one month. Written documentation (including year) of varicella disease from parent, guardian, or health care provider will be accepted. (For the 2007-2008 school year this includes students in grades kindergarten, 1st, 2nd, 3rd, 7th, 8th, 9th, and 10th, plus all out of state transfer students).

*3 doses of DTaP, DTP, DT, or Td vaccine, one given on or after the 4th birthday.

*3 doses of polio vaccine.

*3 doses of pediatric Hepatitis B vaccine or 2 doses of adolescent vaccine if student is 11-15 years of age.

*2 doses of MMR or MMRV vaccine, given on or after 12 months of age and separated by at least one month.

For the 2008-2009 school year Varicella is required for kindergartners, 1st, 2nd, 3rd, 7th, 8th, 9th, and 10th graders, plus all out of state transfers.

Important notice: The immunization record from your physician's office is required and should include the month and year of each immunization signed by the doctor or nurse as proof of immunization.

Please provide the school office with the exam and immunization record no later than August 1, 2008. We appreciate your attention to this important matter.

Sincerely,
Katie Staebell, RN

Health Exam Card **Dental Exam Date ____/____/____**

Last Name:	First Name	Birth date	Sex	Circle Race
______________________	______________	___/___/___	__(M)__(F)	W B Other

Address	Phone	Grade	School
______________________	______________	_____	______________________

Parent's or Guardian's name	Please print name of physician
______________________________	______________________________

****NEBRASKA STATE required immunizations are listed on the reverse side.**

Immunization	Date	Immunization	Date	Immunization	Date

DTP/Td (Diphtheria Tetanus-Pertussis)
1. _____/____/____
2. _____/_____/____
3. _____/_____/____
4. _____/_____/____
5. ___/____/___
6. ____/____/____

POLIO
1. ____/___/____
2. ____/___/____
3. ____/___/____
4. ____/___/____

MMR
1. ____/___/___
2. ____/___/____

HIB 1. ___/___/__ 2. ___/___/__ 3. ___/___/___ 4. ___/___/___

Varicella ____/___/____

Other ____/___/____

HepB 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

PHYSICAL EXAM: B/P ______/______ Pulse _________Respirations__________ HT: _______ WT:_____

Nutritional Status _________________ Hemoglobin or Hematocrit ____________ Urinalysis_______________

Skeletal Development/ Posture ___________________________________ Scoliosis _____________________

Scalp and skin _______________________ Lymph nodes _____________________ Neck ________________

Ears _________________________ Nose __________________________ Throat ________________

Hearing Screening: Pass ______ Fail ______ Referral to Audiologist ___________

Mouth _____________________Teeth & Gums ___________________ Speech _________________________

Heart ______________________________________ Lungs ____

TB Skin Test results: (+) ___ (-) ____ Abdominal Examination: ________________ Hernia? Y ____ N ____

Extremities: Upper ______________________________ Lower ______________________________

Neurological Exam: ____

Mental Health Assessment:____

Medical History: Check any past or present illness of this child the school should be aware of, such as:

____Asthma ____Hepatitis ____Kidney infections ____Cancer ____Physical Limitations ___Diabetes

____Seizure disorder ____Serious Injuries ____ Heart Disease ____Operations

Allergies: ______________________ **Other** (specify)____

REQUIRED Vision Screening: Circle findings

Strabismus (Pass/Fail) Amblyopia (Pass/Fail) Internal eye health (Pass/ Fail) External eye health (Pass/ Fail)

Visual Acuity: Rt eye @ 20ft. 20/___ aided/unaided Lt eye @ 20ft. 20/____ aided/unaided

Rt. Eye 16 inches 20/___ aided/unaided Lt. Eye @16 inches 20/___ aided/unaided

Is this child subject to any illness that may result in a classroom emergency? Yes ( ) No ( )

If yes, please describe: ____

Is this child subject to any condition, which limits: Classroom activities ___Y ____N

Physical Education ___Y ____N

Field Trips ___Y ____N

If yes, please describe: ____

Is this child taking any medication? ____Y ____N If yes, please identify ______________________________

If taking medication at school, please complete on line MEDICATION FORM and submit.

Any other remarks concerning the child's health: ____

Date of Exam ____/____/___ ____

Signature of MD performing exam