300 S. Washington
P. O. Box 890
Lexington, Nebraska 68850-0890
(308) 324-4681
(308) 324-2528 – fax
http://www.lexschools.org

Lexington Public Schools Health Record/ Registero De Salud De Las Escuelas Publicas De Lexington

Your Student will not be admitted to school without this complete information
No se admitará su hijo a la escuela sin esta información

Student Name/Nombre del alumno_____ School/Escuela_____ Grade/Grado_____

Date of Birth/Fecha de Nacimiento_____ Male/Maculino_____ Female/Femenino_____

IMMUNIZATION INFORMATION/INFORMACIÓN SOBRE LAS INMUNIZACIONES

DtaP/DTP/DT ☐ ☐ ☐ ☐ ☐ **4 doses preschool**
K-12: 3doses + 1 after 4yrs age

Td **>7yrs age** ☐ ☐ ☐ **Tdap** ☐ ☐

Polio (OVP or IPV) ☐ ☐ ☐ ☐ ☐

MMR ☐ ☐ ☐ **Hepatitis A** ☐ ☐

Hepatitis B (Hep B or HBV) ☐ ☐ ☐ ☐

Varivax/Chickenpox ☐ ☐ **or Date of Chickenpox Disease** ☐ **(year only)**
Fecha de la varicela

HIB (pre-school only) ☐ ☐ ☐ ☐ ☐
(solo para pre-escolar)

HEALTH HISTORY/ HISTORIA DE SALUD

Allergy to**:** medication/medicina_____ food/comida_____ Other/otros_____
Heart Condition/Condición de corazón_____**Diabetes**_____
Kidney Problems/Condition de riñones_____**Seizures**/Convulsions_____
Operations/Operaciones_____ **Asthma**/Asma_____
Bowel Problems/Problemas del intestino_____**Ear** Infection/Hearing Problems/Infecciones de oídos_____
Psychiatric/Behavior/Emotional concerns/Preocupaciones de comportamiento/emocionales_____
Other health problems or concerns/Otros problems de salud o preocupaciones especiales_____
_____
Medications/Medicinas_____
Additional information/Información adicional_____
_____
_____

I verify the above information is correct to the best of my knowledge. I consent to the release of the health & medical information, obtained through this exam, to be released to School personnel who serve the student. / Verifico que la información anterior escorrecta a que yo sepa. Doy mi consentimiento de que obtengan informaeión de salud y medica por medio de este examen que el personal que sirve al alumno tenga accesso.

***Parent signature/Firma de los padres_____ Date/Fecha_____

PHYSICAL EXAMINATION (to be completed by a physician, physician's asst., or nurse practitioner)

Height_____ Weight_____ BP_____ Urine_____

(List any abnormality)
Skin:_____

HEENT:_____

Neck:_____

Spine:_____

Lungs:_____

Heart:_____

Abdomen:_____

Hernia:_____

Genitalia:_____

Extremities:_____

Neuro:_____

List any additional information regarding this student that may affect safety or optimal performance in school:

_____

_____

Vision: ❑ By checking this box, I am referring the vision exam to an optometrist. (Physicians please inform student of need to schedule eye exam)

		Pass	Fail	Recommend Further Evaluation (see comments)
Amblyopia		_____	_____	_____
Strabismus		_____	_____	_____
Internal Eye Health		_____	_____	_____
External Eye Health		_____	_____	_____
Visual Acuity				
@20 feet	Right 20/_____		Left 20/_____	with/without glasses
@ 16 inches	Right 20/_____		Left 20/_____	with/without glasses

COMMENTS/RECOMMENDATIONS:
_____
_____

Examiner's Signature_____ Date_____