# LEXINGTON PUBLIC SCHOOLS

300 S. Washington
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(308) 324-4681
(308) 324-2528 – fax

**Lexington Public Schools Health Record/ Registro 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

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

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

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## HEALTH HISTORY/ HISTORIA DE SALUD

**Allergy to/Alergía:** Medication/medicina_____ food/comida_____
Other/otros_____

**Heart** Condition/Condición de Corazón Yes ☐ No ☐
**Diabetes** Yes ☐ No ☐
**Kidney** Problems/Condición de Riñones Yes ☐ No ☐ **Seizures**/Convulsions Yes ☐ No ☐
**Asthma**/Asma Yes ☐ No ☐
**Bowel** Problems/Problemas del Intestino Yes ☐ No ☐
**Ear** Infection/Hearing Problems/Infecciones de Oídos Yes ☐ No ☐
**Psychiatric**/Behavior/Emotional concerns/Preocupaciones de comportamiento/emocionales Yes ☐ No ☐
_____
**Operations**/Operaciones Yes ☐ No ☐
_____

**Special Health Care Needs/** Necesidades especiales de atención medical_____
_____

**Other** health concerns/Otros preocupaciones de salud _____
_____

**Regular medications**/Medicinas diarias _____
Additional information/Información adicional_____

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

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.

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

Height_____ Weight_____ BP_____ Urine_____

Allergies_____Surgeries_____

Past Medical History_____

_____

(List any abnormality)
Skin:_____

HEENT:_____

Teeth: _____

Neck:_____

Spine:_____

Lungs:_____

Heart:_____

Abdomen:_____

Hernia:_____

Genitalia:_____

Extremities:_____

Neuro:_____

Is this child subject to any illness that may result in a classroom emergency? Yes ☐ No ☐
Is this child subject to a condition that limits: Classroom activity ☐ Physical education ☐ Competitive sports ☐
Do you feel this child needs further evaluation (psych, speech, OT, PT)? Yes ☐ No ☐
On the basis of this exam, does this child need further referral? Yes ☐ No ☐

_____

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 |
|---|---|---|---|
| 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_____