Requirements for School Entrance

Dear Parent or Guardian:

Per **Nebraska state law**, certain health requirements must be met before a student enters school. Please review the required information outlined below and provide copies of applicable information to the school **before** their first day of school.

Kindergarten student:

- Physical exam
- Vision evaluation
- Immunization record

7th grade student:

- Physical exam
- Immunization record

** If also out of state transfer must have **vision evaluation**, see below.

Student any grade transferring <u>from out of state or previously homeschooled</u>:

- Physical exam
- Vision evaluation
- Immunization record

New student (not Kindergarten or 7th grade) transferring <u>from in state</u>:

- Immunization record

Physical exam - must be done by physician, physician assistant, or nurse practitioner within six months prior to school entrance.
Vision evaluation - testing for amblyopia, strabismus, internal and external eye health and visual acuity by physician, physician assistant, or nurse practitioner within six months prior to school entrance.
Immunization record with dates of required immunizations. (See listing on back of letter.)

Exception to the physical examination or visual evaluation requirement may be made if the parent/guardian submits a written statement refusing a physical examination or visual evaluation.
Exception to the immunization requirement is made only if a medical reason is documented by a physician, physician assistant, or nurse practitioner; or for valid religious reasons documented on a notarized State of Nebraska form.

Sincerely,

Principal VNA School Nurse

Summary of the School Immunization Rules and Regulations

Student Age Group	Required Vaccines
Ages 2 through 5 years enrolled in a school based program not licensed as a child care provider	4 doses of DTaP, DTP, or DT vaccine 3 doses of Polio vaccine 3 doses of Hib vaccine or 1 dose of Hib given at or after 15 months of age 3 doses of pediatric Hepatitis B vaccine 1 dose of MMR or MMRV given on or after 12 months of age 1 dose of varicella (chickenpox) or MMRV given on or after 12 months of age. Written documentation (including year) of varicella disease from parent, guardian, or health care provider will be accepted. 4 doses of pneumococcal or 1 dose of pneumococcal given on or after 15 months of age
Students entering school (Kindergarten or 1st Grade depending on the school district's entering grade)	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 2 doses of varicella (chickenpox) or MMRV given on or after 12 months of age. Written documentation (including year) of varicella disease from parent, guardian, or health care provider will be accepted. If the child has had varicella disease, they do not need any varicella shots.
Students entering 7th grade	Must be current with the above vaccinations AND receive 1 dose of Tdap (contain Pertussis booster)
Students transferring from outside the state at any grade	Must be immunized appropriately according to the grade entered.

Source: Nebraska Immunization Program, Nebraska Department of Health and Human Services. . For additional information, call 402-471-6423.

The School Rules & Regulations are available on the internet: http://dhhs.ne.gov/Pages/reg_t173.aspx (Title 173: Control of Communicable Diseases - Chapter 3; revised and implemented 2011)
Updated 01/26/2018

HEALTH EXAMINATION CARD

Last Name ______ First Name ______ Birthdate ______ (M) (F) (W) (B) (H) (A) (Other) Circle Race

Address ______ Phone ______ School ______ Grade ______

Parent or Guardian's Name ______ Name of Physician ______

The Nebraska School Immunization Rules and Regulations require students to provide proof of immunization before attending school.

PLEASE WRITE MONTH, DAY, YEAR IMMUNIZATIONS WERE GIVEN BELOW:

Immunization	(Month/Day/Year)	Immunization	(Month/Day/Year)	Immunization	(Month/Day/Year)
DTP/Td	1. / /	**Polio (oral)**	1. / /	**Hepatitis B (Hep B)**	1. / /
	2. / /		2. / /		2. / /
	3. / /		3. / /		3. / /
	4. / /		4. / /	**Varcella 1**	1. / /
	5. / /	**MMR 1**	1. / /	**Varcella 2**	2. / /
Tdap	1. / /	**MMR 2**	2. / /	**Other**	/ /
Other	/ /	**Other**	/ /	**Other**	/ /

PHYSICAL EXAM: Blood Pressure ______ / ______ Pulse ______ Respirations ______

General Appearance ______ Height ______ Weight ______ BMI ______ BMI% ______

Nutritional Status ______ Hematocrit or Hgb. ______ Urinalysis ______

Skeletal Development/Posture ______ Scoliosis ______

Scalp and Skin ______ Lymph Nodes ______ Neck ______

Ears ______ Nose ______ Throat ______

Mouth ______ Teeth and Gums ______ Speech ______

Heart ______

Lungs ______ Tuberculin Skin Test: Positive ______ Negative ______

Abdominal Examination ______ Hernia ______

Extremities – Upper ______ Extremities - Lower ______

Neurological exam ______

Mental developmental assessment ______

Vision Exam required for Kindergarten and students transferring from outside of NE (Please document all tests listed below).

Tests	Pass	Fail	Recommend Further Examinations (See comments below)
Amblyopia			
Strabismus			
Internal Eye Health			
External Eye Health			
Visual Acuity With/without Glasses	Right 20/	Left 20/	Both 20/

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

____ asthma ____ concussion ____ physical handicaps
____ allergies ____ diabetes ____ seizure disorder
____ cancer ____ heart disease ____ serious injuries
____ chicken pox ____ kidney infections ____ surgical operations

Other (specify): ______

Hearing Screening:	Pass			Fail		
AUDIO TEST	500	1000	2000	4000	6000	8000
Right Ear						
Left Ear						

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 suggestions? ______

______ Date of exam

______ Signature of Health Care Provider

Phone ______