

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 | <p>4 doses of DTaP, DTP, or DT vaccine</p> <p>3 doses of Polio vaccine</p> <p>3 doses of Hib vaccine or 1 dose of Hib given at or after 15 months of age</p> <p>3 doses of pediatric Hepatitis B vaccine</p> <p>1 dose of MMR or MMRV given on or after 12 months of age</p> <p>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.</p> <p>4 doses of pneumococcal or 1 dose of pneumococcal given on or after 15 months of age</p> |
| Students entering school (Kindergarten or 1 st Grade depending on the school district's entering grade) | <p>3 doses of DTaP, DTP, DT, or Td vaccine, one given on or after the 4th birthday</p> <p>3 doses of Polio vaccine</p> <p>3 doses of pediatric Hepatitis B vaccine or 2 doses of adolescent vaccine if student is 11-15 years of age</p> <p>2 doses of MMR or MMRV vaccine, given on or after 12 months of age and separated by at least one month</p> <p>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.</p> |
| Students entering 7 th grade | <p>Must be current with the above vaccinations</p> <p>AND receive</p> <p>1 dose of Tdap (contain Pertussis booster)</p> |
| 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_1173.aspx (Title 173: Control of Communicable Diseases - Chapter 3; revised and implemented 2011)
Updated 01/26/2018

Name _____ School _____
 Address _____ Date of Birth _____
 Parent or Guardian _____ Phone _____

| Immunizations | Month/Day/Year | Given By: | Medical History | Yes | No | Comments |
|---------------------------------------------------|----------------|-----------|---------------------------------|-----|----|----------|
| DTaP/DTP/TD (Diphtheria-Tetanus- Pertussis) | 1. | | | | | |
| | 2. | | Allergies | | | |
| | 3. | | | | | |
| | 4. | | Asthma | | | |
| | 5. | | | | | |
| Polio | 1. | | Diabetes | | | |
| | 2. | | Glasses/Vision Difficulties | | | |
| | 3. | | | | | |
| | 4. | | Head Injury | | | |
| | 5. | | | | | |
| MMR (Measles-Mumps-Rubella) | 1. | | Hearing Loss or Difficulties | | | |
| | 2. | | | | | |
| Hepatitis B | 1. | | Heart Problems | | | |
| | 2. | | | | | |
| | 3. | | Orthopedic Problems | | | |
| HIB | 1. | | | | | |
| | 2. | | Seizures | | | |
| | 3. | | | | | |
| Varicella | 1. | | Surgery | | | |
| | 2. | | | | | |
| Other: | | | Current Medications | | | |

PHYSICAL EXAMINATION

General Appearance _____ Height _____ Weight _____

Nutrition _____ Skin _____

Skeletal Development _____

Lymph Nodes _____

| | | | | | |
|--------------|------------------|------------------|-----------------------|--------------|----------|
| HEAD | Scalp _____ | | | | |
| | Eyes _____ | Vision | 1. Without Correction | R _____ | L _____ |
| | Ears _____ | Hearing | 2: With Correction | _____ | _____ |
| | Nose _____ | Throat/Tonsils | _____ | _____ | _____ |
| NECK | Thyroid _____ | | | | |
| CHEST | Heart _____ | Size _____ | Rate _____ | Rhythm _____ | BP _____ |
| ABDOMEN | Viscera _____ | Liver _____ | | cm _____ | |
| | Hernia _____ | Genitals _____ | | | |
| EXTREMITIES | Upper _____ | Lower _____ | | | |
| NEUROLOGICAL | | | | | |
| LAB TESTS | Urinalysis _____ | Hematocrit _____ | | | |
| | Other _____ | | | | |

RECOMMENDATIONS Physical Activity: Unrestricted _____ Moderate _____ Minimum _____
 Remarks and Suggestions: _____

Date of Exam _____ Signature of Examining Physician _____