

Lynette Mitzel  
Director of Student Programs  
512 W Philip Ave  
P.O. Box 139  
Norfolk, NE 68702-0139



Telephone: (402)644-2500  
Fax: (402)644-2506  
lynnettemitzel@npsne.org  
[www.norfolkpublicschools.org](http://www.norfolkpublicschools.org)

January, 2026

**Norfolk Senior High**

Jason Settles, Principal  
Blair Brink, Nurse  
644-2529

**Norfolk Junior High**

Beau Viergutz, Principal  
Cindy Fox, Nurse  
644-2516

**Norfolk Middle School**

Amy Brown, Principal  
Cindy Fox, Nurse  
644-2569

**Bel Air Elementary**

Trisha Andreasen, Principal  
Amy Rice Hoffman, Nurse  
644-2539

**Grant Elementary**

Paige Hastings, Principal  
Amy Rice Hoffman, Nurse  
644-2544

**Jefferson Elementary**

Jamie London, Principal  
Cori Pena, Nurse  
644-2546

**Lincoln Elementary**

Angela Hausmann, Principal  
Amy Rice Hoffman, Nurse  
644-2550

**Washington Elementary**

Ryan Specht, Principal  
Amy Rice Hoffman, Nurse  
644-2557

**Westside Elementary**

Tracy Lichty, Principal  
Cori Pena, Nurse  
644-2561

**Woodland Park Elementary**

Bruce Strong, Principal  
Cori Pena, Nurse  
644-2565

Dear Parents:

Health is a very important aspect of the total education program in Norfolk Public Schools. All students are required by the State of Nebraska to have the following; **THE REQUIREMENTS OF CURRENT IMMUNIZATION RECORDS, PHYSICAL AND VISION EXAMS, AND BIRTH CERTIFICATE DOCUMENTATION ARE DUE TO THE SCHOOL OFFICE WEDNESDAY, JULY 29th, 2026. YOUR CHILD WILL NOT BE ALLOWED TO ATTEND SCHOOL WITHOUT THIS DOCUMENTATION.**

The immunization information should be completed with the month, day and year of each immunization. The minimum requirements for admission to kindergarten will be:

**3 doses of DTaP, DTP, or DT vaccine,**

One given on or after the 4<sup>th</sup> birthday

**3 doses of Polio vaccine**

**2 doses of Measles-Mumps-Rubella (MMR),**

Given on or after 12 months of age and separated by at least one month

**3 doses of Hepatitis B vaccine**

**2 doses of Varicella given on or after 12 months of age or documentation of having the Chickenpox disease, documentation form available at the school office**

Any needed immunizations may be obtained at your local physician's office or the Northeast Nebraska Community Action Partnership in Norfolk at 1405 Riverside Blvd. Call 402-844-4422 for an appointment. If no answer, please leave your name and phone number; someone will call you back. The Midtown Health Clinic, located at 302 W. Philip Ave. and the Elkhorn Logan Valley Public Health Department (ELVPHD), located at 128 W Norfolk Ave., are also resources for immunizations. Call the Midtown Health Clinic at 402-371-8000 or the ELVPHD at 402-529-2233 to schedule an appointment.

A "visual evaluation is required by a physician, a physician assistant, an advanced practice registered nurse or an optometrist within six months prior to the entrance of a child into the beginner grade, or in the case of a transfer from out of state, to any other grade of the local school. This vision testing shall consist of tests for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity." The cost of this examination will be borne by the parent or guardian of each child. If you need assistance please contact your school. Parent objection forms to the physical examination or visual examination are available from your child's school.

Children are now eligible to attend kindergarten if they turn 5 years old on or before July 31<sup>st</sup>.

We hope your child enjoys a successful and healthy school experience. If you need help with any school problems, please call your building principal or contact me at 402-644-2500.

Sincerely,

Lynette Mitzel  
Director of Student Programs

**NORFOLK PUBLIC SCHOOLS  
HEALTH SERVICES  
REPORT OF VISION EVALUATION**

**Please return this form to your child's school health office.**

Effective with the 2006-2007 school year, Nebraska State Statute requires students entering kindergarten (or first grade, if not enrolled in kindergarten) to provide evidence of vision evaluation within six months prior to entry. This requirement also applies to out-of-state transfers to any grade. The evaluation may be performed by a physician, physician assistant, advanced practice registered nurse, or vision professional (optometrist or ophthalmologist). Children are exempt from this requirement when the parent/guardian provides a written statement of objection. For more information about the vision requirement, including the availability of resources for low-income families, please contact the school nurse in your child's school, or the Nebraska Optometric Association (<http://www.noaonline.org/> or telephone 402-474-7716).

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Date: \_\_\_\_\_

Student Status (*check one*): ☐ Beginner Grade ☐ Transfer Student from Out of State

| <b>REQUIRED TESTS*</b> | <b>Pass</b>                    | <b>Fail</b> | <b>Recommend<br/>Further Evaluation<br/>(comments noted below)</b> |
|------------------------|--------------------------------|-------------|--------------------------------------------------------------------|
| Amblyopia              | _____                          | _____       | _____                                                              |
| Strabismus             | _____                          | _____       | _____                                                              |
| Internal Eye Health    | _____                          | _____       | _____                                                              |
| External Eye Health    | _____                          | _____       | _____                                                              |
| Visual Acuity          |                                |             |                                                                    |
|                        | Right eye @ distance (20 ft.): | 20/____     | aided/unaided                                                      |
|                        | Left eye @ distance (20 ft.):  | 20/____     | aided/unaided                                                      |
|                        | Right eye @ near (16 in.):     | 20/____     | aided/unaided                                                      |
|                        | Left eye @ near (16 in.):      | 20/____     | aided/unaided                                                      |

*\*A vision evaluation consisting of these required tests meets the legal requirements for the State of Nebraska but is not a complete eye examination such as most eye doctors perform.*

| <b>ADDITIONAL TESTS</b>         | <b>Pass</b> | <b>Fail</b> | <b>Recommend<br/>Further Evaluation</b> |
|---------------------------------|-------------|-------------|-----------------------------------------|
| Eye Alignment at Distance       | _____       | _____       | _____                                   |
| Eye Alignment at Near           | _____       | _____       | _____                                   |
| Depth Perception                | _____       | _____       | _____                                   |
| Color Vision                    | _____       | _____       | _____                                   |
| Focusing Amount                 | _____       | _____       | _____                                   |
| Focusing Flexibility            | _____       | _____       | _____                                   |
| Focusing Lag (Accuracy)         | _____       | _____       | _____                                   |
| Convergence (Crossing) Ability  | _____       | _____       | _____                                   |
| Saccade (Rapid) Eye Movement    | _____       | _____       | _____                                   |
| Pursuit (Tracking) Eye Movement | _____       | _____       | _____                                   |
| Other: _____                    | _____       | _____       | _____                                   |

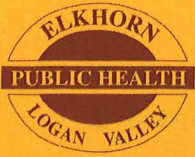
**COMMENTS/RECOMMENDATIONS:** \_\_\_\_\_

\_\_\_\_\_

Evaluation performed by: \_\_\_\_\_ Date: \_\_\_\_\_

(signature)

\_\_\_\_ O.D. \_\_\_\_ M.D. \_\_\_\_ P.A. \_\_\_\_ A.P.R.N.



# Elkhorn Logan Valley Public Health Immunization Clinics

Appointments are required and you must bring a a current copy of your child's immunization record.

Norfolk Office:  
128 W. Norfolk Ave  
Norfolk, NE 68701

Wisner Office:  
2104 21st Circle  
Wisner, NE 68791

Tekamah Office:  
1121 S 13th St.  
Tekamah, NE 68061



**Public Health**

*Healthy people  
living in healthy  
communities.*

Do you have  
questions  
about which  
vaccines are  
needed?  
Please  
contact  
us...we are  
here to help!

402-529-2233  
Elvphd.org

Please call 402.529.2233 or scan QR Code to  
Schedule



## Our Locations:

### **NORFOLK:**

128W Norfolk Ave.

Office hours: 8:30am to 4pm, Monday—Thursday

### **WISNER:**

2104 21st Circle

Office hours: 8:30am to 4pm, Monday—Thursday

### **TEKAMAH:**

1121 S. 13th St.

Office hours: 8:30am to 4pm, Monday—Thursday

## Who can receive vaccines at our clinics?

- Any adult or child who is privately insured (most private insurance is accepted). We carry all recommended vaccines and also provide travel vaccines.
- Any child that qualifies for the Vaccines for Children (VFC) program (children with Heritage Health and those who are uninsured or underinsured). This program provides recommended child vaccines at no charge. An optional donation is encouraged.
- Any adult that qualifies for the Adult Immunization Program (adults who are uninsured). This program provides select adult vaccines at no charge. An optional donation is encouraged.



**“People helping people: empowering individuals, strengthening families and enriching communities in Northeast Nebraska.”**

[www.nencap.org](http://www.nencap.org)

**2026 NENCAP CLINIC SCHEDULE  
WIC & IMMUNIZATION PROGRAMS**

**Please call for appointments (402) 385-6300 or (800) 445-2505**

**Antelope County Clinic:**

**NELIGH:** American Legion- 115 W. 3<sup>rd</sup> Street

**10:30 - 2:30:** January 8, February 5, March 5, April 2, May 7, June 4, July 9, August 6, September 3, October 8, November 5, December 3

**Cuming County Clinics:**

**WEST POINT:** Grace Lutheran Church- 104 S. Colfax St

**9:30 - 3:30:** January 12, 27; February 9, 24; March 9, 24; April 13, 28; May 11, 26; June 8, 23; July 13, 28; August 10, 25; September 14, 22; October 16, 27; November 9, 24; December 14, 22

**WISNER:** Christ Lutheran Church, 517 8<sup>th</sup> St

**9:30 - 3:30:** January 7, February 4, March 4, April 1, May 6, June 3, July 1, August 5, September 2, October 7, November 4, December 2

**Knox County Clinic:**

**CREIGHTON:** NENCAP Building, 808 Chase Ave

**10:30 - 2:30:** January 20, February 17, March 17, April 21, May 19, June 16, July 21, August 18, September 15, October 20, November 17, December 15

**Madison County Clinic:**

**NORFOLK:** 8:00 - 4:30: Call (402)844-4422

NENCAP Building - 1405 Riverside Blvd.- WIC/Immunization Appointments daily

**Pierce County Clinics:**

**PLAINVIEW:** Our Savior's Lutheran Church, 1<sup>st</sup> & Pilcher St

**10:30 - 2:30:** January 28, February 25, March 25, April 22, May 27, June 24, July 22, August 26, September 23, October 28, November 20, December 23

**Wayne County Clinic:**

**WAYNE:** United Methodist Church, 516 N Main Street

**9:30 - 3:30:** January 6, 23; February 3, 20; March 3, 16; April 7, 20; May 5, 18; June 2, 15; July 7, 20; August 4, 17; September 1, 21; October 6, 19; November 3, 16; December 1, 21

**There must be a parent/guardian or proxy form accompanying the child.**

**\*Immunization records are required at each clinic visit. \***

**It is important to follow up with your family physician for well-baby or childhood checkups on a regular schedule.**

**NENCAP WIC/Immunization Programs are equal opportunity providers.**

# NORFOLK SCHOOL HEALTH EXAMINATION CARD

Last Name ..... First Name ..... Date of Birth ..... Sex .....  
 Address ..... Phone ..... School .....  
 Parent's Name (or Guardian) .....

| Disease History         | Date | Immunizations | 1st Date | 2nd Date | 3rd Date | 4th Date | 5th Date | 6th Date | Significant Medical History |
|-------------------------|------|---------------|----------|----------|----------|----------|----------|----------|-----------------------------|
| Rheumatic Fever         |      | Polio         |          |          |          |          |          |          |                             |
| Tuberculosis            |      | DTP or DT/TD  |          |          |          |          |          |          |                             |
| Frequent Colds          |      | MMR           |          |          |          |          |          |          |                             |
| Red Measles             |      | Hepatitis B   |          |          |          |          |          |          |                             |
| Rubella (3 day measles) |      | HIB           |          |          |          |          |          |          |                             |
| Mumps                   |      | Varicella     |          |          |          |          |          |          |                             |
| Chicken Pox             |      | TB            |          |          |          |          |          |          |                             |
| Allergy                 |      |               |          |          |          |          |          |          |                             |
| Seizure Disorder        |      |               |          |          |          |          |          |          |                             |
| Diabetes                |      |               |          |          |          |          |          |          |                             |
| Other                   |      |               |          |          |          |          |          |          |                             |

PARENTS: PLEASE FILL IN THE ABOVE BEFORE TAKING TO M.D.

## PHYSICAL EXAMINATION (cont'd)

Last Name ..... First Name .....  
 General Appearance ..... Height ..... Weight .....  
 Nutrition ..... Skin { Clear ..... Eczema ..... Glands .....  
 Skeletal Development .....  
 Glands .....  
 Anemia .....

|                              |                                                                     |                                        |      |
|------------------------------|---------------------------------------------------------------------|----------------------------------------|------|
| <b>HEAD</b>                  | Scalp .....                                                         | Right                                  | Left |
|                              | Eyes.....                                                           |                                        |      |
|                              | Ears.....                                                           | Hearing.....                           |      |
|                              | Nose .....                                                          | Throat-Tonsils.....                    |      |
| <b>NECK</b>                  | Thyroid .....                                                       |                                        |      |
| <b>CHEST</b>                 | Heart..... Size ..... Rate..... Rhythm ..... B.P. ....              |                                        |      |
| <b>ABDOMEN</b>               | Viscera ..... Hernia ..... Genitals .....                           |                                        |      |
| <b>Extremities</b>           | Upper ..... Lower .....                                             |                                        |      |
| <b>Neurological</b>          | Chorea ..... Stutter ..... Nail Biting .....                        |                                        |      |
| <b>URINALYSIS</b>            |                                                                     |                                        |      |
| <b>RECOMMEN-<br/>DATIONS</b> | Physical Activity - Unrestricted ..... Moderate ..... Minimum ..... |                                        |      |
|                              | Remarks and suggestions.....                                        |                                        |      |
|                              | Date of Exam.....                                                   |                                        |      |
|                              |                                                                     | Signature of Examining Physician ..... |      |

To receive a Nebraska State certified copy of your child's birth certificate contact:

**In person:**

**Nebraska Health and Human Services  
209 North 5th Street  
Norfolk, NE 68701-4093  
8:00 a.m.-5:00 p.m.  
402-370-3120**

**Write to:**

**Vital Records  
P. O. Box 95065  
Lincoln, NE 68509-5065**

**Or online:**

**<https://nevitalrecords-dhhs.ne.gov>**

The cost for the birth certificate copy is \$17.00. The department will also need the child's full name, birth date, city born in, county born in, father's full name, and mother's full maiden name.

BRTHMEMO 1/17/2024

---