Name of Student (Last / First / Middle) Grade School

PHYSICAL EXAMINATION

(to be completed by a physician, physician's assistant, or nurse practitioner)

Height ________ Neck ________ Mouth/Teeth ________

Weight ________ Lungs ________ Abdomen ________

BP ________ Eyes ________ Spine ________

Pulse ________ Ears ________ Scoliosis ________

Heart ________ Skin ________ Extremities ________

Urinalysis results ______________ Hgb/Hct results ______________

Hearing Test (please circle) Normal / Abnormal

Left Ear	Right Ear	Hz
dB	dB	500
dB	dB	1000
dB	dB	2000
dB	dB	400

Comments ____

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

____

A School Vision Evaluation is required for all children within six months prior to entering Nebraska schools for the first time (includes beginner grades including Kindergarteners, transfers, and other students new to Nebraska) [NE revised Statute 79-214]

Vision Test (please circle) Normal / Abnormal

Required Tests	Pass	Fail	Recommendations	Vision	Glasses / Contacts / Neither
Amblyopia				Right eye @ Far (20')	20 / _____ aided / unaided
Strabismus				Left eye @ Far (20')	20 / _____ aided / unaided
Internal Eye Health					
External Eye Health				Right eye @ Near (16")	20 / _____ aided / unaided
Visual Acuity				Left eye @ Near (16")	20 / _____ aided / unaided

Provider's Signature ______________________________ *Date* ____________

DENTAL EXAMINATION *(optional)*

Is oral hygiene adequate Yes / No Number of fillings present______ Number of restorations needed______

Recommendations: ____

____

Dentist's Signature ______________________________ *Date* ____________

WAIVER of PHYSICAL and/or VISION EXAMINATION

I, the parent/guardian of ______________________________, do not feel it necessary for he/she to
Name of Child
a physical and/or vision examination and therefore exercise my right to waiver his/her physical and/or vision examination.

Parent/Guardian Signature ______________________________ *Date* ____________

Nebraska Law requires a physical examination prior to entrance into kindergarten, 7th grade, and all students transferring into the State of Nebraska.

Name of Student (Last / First / Middle) ____ Birthdate ____ Age ____ Grade ____ School ____

Name of Parent/Guardian ____ Address ____ Phone / Cell Number ____

Family Provider ____ City ____ Family Dentist ____ City ____

IMMUNIZATIONS

DtaP / DTP/Tdap / DT/Td #1____ #2____ #3____ #4____ #5____ #6____

Polio (IPV/OPV) #1____ #2____ #3____ #4____ #5____

HIB #1____ #2____ #3____ #4____

PCV/Prevnar #1____ #2____ #3____ #4____

MMR / MMRV #1____ #2____

Hepatitis B (Hep B or HBV) #1____ #2____ #3____ #4____

Hepatitis A #1____ #2____ Menactra (Meningitis Vaccine) #1____ #2____

RotaTeq (Rota Virus Vaccine)) #1____ #2____ #3____

Varicella (Chickenpox Vaccine) #1____ #2____ Year of Chickenpox Disease ____

HPV/Gardisil (Females Only) #1____ #2____ #3____

Other Immunizations____

HEALTH HISTORY (Please check Yes or No for each)

Bowel / Bladder Problems ☐ Yes ☐ No Asthma ☐ Yes ☐ No Meds ____

Kidney Problems ☐ Yes ☐ No Asthma Action Plan ☐ Yes ☐ No

Hearing Loss ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Meds ____

ADHD ☐ Yes ☐ No Meds ____

Allergy to meds ☐ Yes ☐ No Explain Reaction____

Allergy to food ☐ Yes ☐ No Explain Reaction____

Other allergies ☐ Yes ☐ No Explain Reaction____

Diabetes ☐ Yes ☐ No Meds ____

Seizures/Convulsions ☐ Yes ☐ No Explain / Meds ____

Concussions / Dates ☐ Yes ☐ No Explain / Meds ____

Additional Medications ☐ Yes ☐ No Explain / Meds ____

Family History of Early Cardiac Death Explain ____

Psychiatric/Behavior/Emotional Concerns Explain ____

Surgery / Dates Explain ____

Other Health Problems Explain ____

Additional Information ____

I verify that the above information is correct to the best of my knowledge.

____

Parent / Guardian Signature *Date*