

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 waive 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/Gardasil (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