

Department of Health and Human Services

Physical Examination Report

Name of School (if desired)

By signing below, the parent/guardian of

The school board shall require evidence of (a) a physical examination by a physician, a physician assistant, or an advanced practice registered nurse...within six months prior to the entrance of a child into the beginner grade and the seventh grade or, in the case of a transfer from out of state, to any other grade of the local school; and (b) for school year 2006-07 and each school year thereafter, a visual evaluation by a physician, 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, which consists of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity, except that no such physical examination or visual evaluation shall be required of any child whose parent or guardian objects in writing. The cost of such physical examination and visual evaluation shall be borne by the parent or guardian of each child who is examined. Nebraska Revised Statutes 79-214 (excerpt).

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for physical examination in Nebraska schools. No specific form is required by the statute. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success.

Name of Student

School Grade	release of the health						Name of S	School	
Student Address Zip Age Sex: M Description Physician Name Physician Phone Physician Phone Physician Physi	Signature			Printed Name/Relati	onship to Student	***************************************			Date
Student Address Zip Age Sex:	Student Name				School			Grade	
Physician Name PHYSICAL FINDINGS (use back for comments or recommendations) Height Weight Weight Medical Normal Abnormal Find Appearance	Student Address		***************************************		Zip	Age			ı DF
PHYSICAL FINDINGS (use back for comments or recommendations) Height	Physician Name						1	COX: DIV	· • • • • • • • • • • • • • • • • • • •
Medical Normal Abnormal Find Appearance		PH	YSICAL FINDIN	GS (use back fo	or comments or r	acommendation			
Blood Pressure			***************************************	OO (use back it		ecommendations	<u> </u>		
Seyes/ears/nose/throat Lymph Nodes Lym					1 			Abnorma	l Findings
Lymph Nodes Heart (note murmur if present) December 1 Lymph Nodes Heart (note murmur if present) December 2 Lymph Nodes Lymph No			uise						
Heart (note murmur if present)	Jrinalysis	····			<u> </u>			 	
Pulses (inc. Femoral)	Hemoglobin/Hct							 	
Lungs Abdomen Lings Skin Lings Lin	Audiometric Screening	Report						1	***************************************
Abdomen	500	1000	2000	4000		<u> </u>		 	
Skin									······································
DTP Td Polio MMR Hib Hep B Varicella DTP Td Polio Td Td Td Td Td Td Td T	LE								
Other (list) Other (list)	mmunizations given d	uring todav's vi	sit:	······		al .			
Spine	□DTP □Td □Polic	MMR 🗆	Hib □ Hep B	☐ Varicella	<u> </u>				
Wisul Evaluation Report PASS FAIL Evaluation	☐ Other (list)			I 1					
Visual Evaluation Report PASS FAIL Evaluation Amblyopia	Please attach copy of	immunization i	record on file.)						·····
Amblyopia			Recom	mend Further				<u> </u>	
Strabismus	Visual Evaluation Report PASS FAIL Evaluation Amblyopia			1			 	······································	
Internal Eye Health									
External Eye Health							<u> </u>		
Visual Acuity							 	· · · · · · · · · · · · · · · · · · ·	
20 feet: Right 20/ Left 20/ with/without glasses 16 inches: Right 20/ Left 20/ with/without glasses Required medication on a daily or episodic routine: Please check classification Regular: Student may participate in the regular program of physical education, recreation, intramurals, athletics or related a without undue risk or injury. Adapted: Student has a condition which might risk sustaining injury from participation in the regular program or needs a special a program as indicated by the consulting physician. Reexamine each year. Student has a severe handicap which might risk sustaining injury from participation in the regular or adapted programs. Students should be reexamined for possible reclassification at the end of the exemption period. Please check certification Certified: Student has passed the physical examination successfully and is physically able to participate in interscholastic at Activities student should not participate in: Significant findings/chronic health concerns Your signature below indicates completion of physical exam and review of health history. Clinic/Practice Name (please print) Physician Address					oliosis DNo		J L J		
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Physician Address				E	xamining Physician (Signa	ature Required)			
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Return to School Health Office FH-42 (4404	i ilyər			R	eturn to School Health Off	ice	***************************************	j=1 1 4/	7/44040) 4

SCHOOL VISION EVALUATION Report Form

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) [Nebraska Revised Statute 79-214]

Name:	***************************************	Dat	Date of Birth: Date: Transfer Student from Out of State			
School:		Dat				
Student Status (ch	eck one): Begin	ner GradeTra				
				ommend		
REQUIRI	ED TESTS*	Pass	Fail	Further Evaluation		
Amblyopia Strabismus			(comm	ents noted below)		
Internal Ey		**************************************	***************************************	Address of the second second		
External E	ye Health					
	Right eye	distance (20 ft.): 20	/ aided/u	ınaided		
	Left eye @	distance (20 ft.): 20	/ aided/u	ınaided		
	Right eye @	near (16 in.): 20	/ aided/u	ınaided		
	Left eye @	distance (20 ft.): 20 near (16 in.): 20 near (16 in.): 20	/ aided/u	naided		
	valuation consisting of braska but is not a com	these required tests m	eets the legal re	quirements for the		
COMMENTS/RE	ECOMMENDATIONS	S:				
Evaluation perform	rmed by:(sign	nature)	O.DM	.D P.A A.P.R.N		
Office Phone Nur	nber: (_	Date	:		