

PHYSICAL EXAMINATION FORM

Grade _____

Dear Parents/Guardians: **Nebraska Law LB59** - requires a physical examination by the physician of your choice, prior to entrance into Kindergarten, 7th grade and new students to Nebraska. This may be done 6 months prior to entering school. Return this completed form to the school where your child will be attending. An objection for a physical exam may be submitted to the school office in writing and dated by the parent or guardian.

Student's Last Name	First	Middle	Birthdate	Age	Phone #
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Parent/Guardian	Address
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Physician	Phone #	Dentist	Phone #
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MEDICAL RECORD

PHYSICAL EXAM

Height _____
 Weight _____
 Blood Pressure _____/_____
 Heart Rate _____
 Urinalysis _____
 Hgb/Hct _____
 Vision: R20/____ L20/____
 Hearing: R____/15 L____/15
 Eyes _____
 Ears _____
 Nose _____
 Throat _____
 Neck _____
 Heart Rate _____
 Lungs _____
 Abdomen _____
 Genitalia _____
 Scoliosis _____
 Skin _____
 Ortho _____

IMMUNIZATION RECORD

DTaP, DTP	3.
DT,Td	1. 4.
	2. 5.

POLIO	
	1. 3.
	2. 4.

MMR #1	1.
MMR #2	2.

HIB	
	1. 3.
	2. 4.

HEP B	1. 3.
	2.

VARICELLA	1.
or	2.
Lab Evidence	3.

HEALTH HISTORY

If this child has had any of the diseases or conditions listed below, please give date of onset, specify allergies, surgery, medication, etc.

ADD/ADHD _____
 Allergies _____
 Asthma _____
 Behavioral Disorder _____
 Chicken Pox (Year) _____
 Diabetes _____
 Ear Infections _____
 Fractures _____
 Glasses/contacts _____
 Headaches _____
 Hearing Loss _____
 Seizures _____
 Sleep disorder _____
 Surgeries _____
 Syndrome _____
 Medication _____
Name of Meds. & reason

Physician's Signature	Date
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DENTAL EXAMINATION

Is oral hygiene adequate? _____ Number of fillings present: _____ Number of restoration needed: _____

Date (s) restorations to be completed: _____ Recommendations: _____

Dentist's Signature	Date
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Parent/Guardian Signature	Date
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SCHOOL VISION EVALUATION REPORT FORM

A School Vision Evaluation is required for all children within 6 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: _____

Date of Birth: _____

School: _____

Date: _____

Student Status: (check one): Beginner Grade

Transfer Student from Out of State

REQUIRED TESTS*	Pass	Fail	Recommend Further Evaluation (comments noted below)
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 @ distance (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.

ADDITIONAL TESTS	Pass	Fail	Recommend Further Evaluation
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.

PARENT/GUARDIAN STATEMENT OF OBJECTION (WAIVER) TO REQUIREMENT FOR VISION EVALUATION

On behalf of my student _____, I object to the required vision evaluation as legislated in NSS 79-214. I understand provisions of the law allow me to waive this requirement for my child by my signed statement.

Signature of Parent/Guardian

Date