

**Nebraska Law requires a physical examination prior to entrance into kindergarten, 7<sup>th</sup> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meds _____
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma Action Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meds _____
ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meds			_____
Allergy to meds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain Reaction			_____
Allergy to food	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain Reaction			_____
Other allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain Reaction			_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Meds			_____
Seizures/Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain / Meds			_____
Concussions / Dates	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain / Meds			_____
Additional Medications	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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 \_\_\_\_\_