NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Physical Examination Report

Name of School (if desired)

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.

By signing below, the parent/guardian of _____ **consents for the**
Name of Student

release of the health and medical information contained herein to be released to _____
Name of School

_____ _____ _____
Signature | Printed Name/Relationship to Student | Date

Student Name	School		Grade
Student Address	Zip	Age	Sex: ☐ M ☐ F
Physician Name			

PHYSICAL FINDINGS (use back for comments or recommendations)

Height	Weight
Blood Pressure	Pulse
Urinalysis	
Hemoglobin/Hct	

Audiometric Screening Report

	500	1000	2000	4000
RE				
LE				

Immunizations given during today's visit:
☐ DTP ☐ Td ☐ Polio ☐ MMR ☐ Hib ☐ Hep B ☐ Varicella
☐ Other (list)_____
(Please attach copy of immunization record on file.)

Visual Evaluation Report	PASS	FAIL	Recommend Further Evaluation
Amblyopia	☐	☐	☐
Strabismus	☐	☐	☐
Internal Eye Health	☐	☐	☐
External Eye Health	☐	☐	☐
Visual Acuity	☐	☐	☐

20 feet: Right 20/_____ Left 20/____ with/without glasses

16 inches: Right 20/____ Left 20/____ with/without glasses

Medical	Normal	Abnormal Findings
Appearance	☐	☐
Eyes/ears/nose/throat	☐	☐
Lymph Nodes	☐	☐
Heart (note murmur if present)	☐	☐
Pulses (inc. Femoral)	☐	☐
Lungs	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Musculoskeletal	☐	☐
Neck	☐	☐
Spine	☐	☐
Shoulder/arm	☐	☐
Wrist/hand	☐	☐
Elbow/forearm	☐	☐
Hip/thigh	☐	☐
Knee	☐	☐
Leg/ankle	☐	☐
Foot	☐	☐
Evidence of Scoliosis	☐ No	☐ Yes
Evidence of Hernia	☐ No	☐ Yes
Stigmata of Marfan's Syndrome	☐ No	☐ Yes

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 activities 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 adapted program as indicated by the consulting physician. Reexamine each year.

☐ Exempt: Student has a severe handicap which might risk sustaining injury from participation in the regular or adapted programs. These 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 athletics. Activities student should **not** participate in:_____

Significant findings/chronic health concerns_____

Your signature below indicates completion of physical exam and review of health history.

Date_____ Signed _____
Examining Physician (Signature Required)

Clinic/Practice Name (please print)_____Physician Phone_____

Physician Address _____
Return to School Health Office

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services

Certification of Physical Examination

Name of School (if desired)

The school board shall require evidence of (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 2006-6007 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, with 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 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 b the parent or guardian of each child who is examined. Nebraska Revised Statutes 79-214 (excerpt).

A printed or typewritten form signed by a licensed physician, physician assistant, or nurse practitioner indicating that a physical examination was administered on a specific date within the previous six-month period on a specifically named individual constitutes sufficient evidence of a physical examination by a qualified examiner. Nebraska Administrative Code Title 173 Chapter 3 Section 3-006 (rev. 2/7/04).

Student Name	School		Grade
Student Address	Zip	Age	Sex: ☐ M ☐ F
Physician Name			

PART I: By signing below, the qualified medical examiner (physician, physician assistant, advanced practice registered nurse) certifies that the student specified received a complete physical examination, as required by Nebraska Revised Statute 79-214, for entry into school at the beginner grade (Kindergarten or 1st grade), seventh grade, or out-of-state transfer to any grade.

Date of Physical Examination:_____

Signature of Medical Examiner

Printed Name of Medical Examiner

Visual Evaluation Completed: ☐ Yes ☐ No
If yes: provide report:

Visual Evaluation Report	PASS	FAIL	Recommend Further Evaluation
Amblyopia	☐	☐	☐
Strabismus	☐	☐	☐
Internal Eye Health	☐	☐	☐
External Eye Health	☐	☐	☐
Visual Acuity	☐	☐	☐

20 feet: Right 20/_____ Left 20/____ with/without glasses

16 inches: Right 20/____ Left 20/____ with/without glasses

PART II: As parent/guardian of the student named above, I consent for the release of this information to:

Name of School

Parent/guardian signature

Date

Printed Name/Relationship to Student

Examiner Address or Clinic Stamp:

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Report of Visual Evaluation

School Name (if desired)

Effective with the 2006-07 school year, Nebraska State Statute 79-214 requires students entering kindergarten (or first grade, if not enrolled in kindergarten) to provide evidence of visual evaluation within six months prior to entry. This requirement also applies to out-of-state transfers to any grade. The vision evaluation may be performed by a physician, physician assistant, advanced practice nurse practitioner, or vision professional (optometrist or ophthalmologist). Students are exempt from this requirement when the parent/guardian provides a written statement of objection. For more information about the vision evaluation requirement, including the availability of resources for low-income families, please contact the school.

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for visual evaluation 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.

By signing below, the parent/guardian of _____ **consents for the**
Name of Student

release of the health and medical information contained herein to be released to _____
Name of School

_____ _____ _____
Signature **Printed Name/Relationship to Student** **Date**

Student Name	Student ID#
School	

Visual Evaluation Report	**PASS**	**FAIL**	**Recommend Further Evaluation**
Amblyopia	☐	☐	☐
Strabismus	☐	☐	☐
Internal Eye Health	☐	☐	☐
External Eye Health	☐	☐	☐
Visual Acuity	☐	☐	☐

20 feet: Right 20/_____ Left 20/____ with/without glasses

16 inches: Right 20/____ Left 20/____ with/without glasses

Comments: _____

Signature of Examiner	Date of Exam

Please enter School Name here

Health History
(Preschool through Sixth Grade)

Nebraska Department of Health and Human Services

Student Name_____ Date of Birth_____ Sex: M ☐ F ☐

Parent/Guardian Name:_____ Address:_____

Parent/Guardian Telephone:_____

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's safety and educational success. Please contact the school nurse if you have questions. Return the completed form to the school health office.

A. Current Health Status

1. Does your child take medicine or supplements regularly? ☐ No ☐ Yes
   Please list:

2. Does your child have a health condition now under treatment? ☐ No ☐ Yes
   Please list:

3. Does your child currently have allergies? ☐ No ☐ Yes
   Please list:

4. Any concern's about your child's health?

5. Date of last medical exam_____ Dr._____

6. Date of last dental exam_____ Dr._____

7. Does your child have current health insurance coverage? ☐ No ☐ Yes

8. Would you like more information about the state health insurance program? ☐ No ☐ Yes

B. Check conditions your child has experienced and the date.

☐ Sleeping problem_____	☐ Hives_____	☐ Loss of consciousness_____
☐ Eating problem_____	☐ Chicken Pox_____	☐ Kidney problems/bedwetting_____
☐ Coordination problems_____	☐ Hay Fever_____	☐ Heart problems_____
☐ Tires easily_____	☐ Asthma_____	☐ Diabetes_____
☐ Recurrent headaches_____	☐ Nosebleeds_____	☐ Rheumatic fever_____
☐ Weight problem_____	☐ Blow to the head_____	☐ Pneumonia_____
☐ Eczema_____	☐ Broken bones_____	☐ Convulsions or seizures_____
☐ Behavior/emotional concerns_____		

C. Illness and Accidents

Please explain each "yes" answer.

1. Has there been more than one ear infection each year? ☐ No ☐ Yes
   Comments:

2. Has there been any hearing problems? ☐ No ☐ Yes
Comments:

3. Has there been a vision problem? ☐ No ☐ Yes
If yes, when were they last fitted for glasses?_____

4. Has your child been hospitalized or had surgery? ☐ No ☐ Yes
If yes, please specify:

D. Previous History

Please explain any "yes" answers.

1. Were there any significant health concerns during pregnancy? ☐ No ☐ Yes
Comments:

2. Was the pregnancy less than nine months? ☐ No ☐ Yes

3. Were there medical problems at birth? ☐ No ☐ Yes
Comments:

4. Birth Weight:_____

5. At what age did your child walk alone?_____

6. At what age did your child say words with meaning?_____

7. Was your child ever enrolled in Early Childhood Special Education or HeadStart? ☐ No ☐ Yes
Date_____ School attended_____

E. Family History

1. List who lives in the home

2. List any family health problems

_____ _____ _____
Completed by Relationship to student Date

Please enter School Name here

Health History
(Seventh Grade through High School)

Nebraska Department of Health and Human Services

Student Name_____ Date of Birth_____ Sex: M ☐ F ☐

Parent/Guardian Name:_____ Address:_____

Parent/Guardian Telephone:_____

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's health care provider. Please contact the school nurse if you have questions. Return the completed form to the school health office.

Please check the third box for the questions you don't know the answer to. Explain "yes" answers below.

	Y	N	?
1. Has there been a medical illness or injury since the last checkup or sports physical?	☐	☐	☐
2. Has the student ever been hospitalized overnight?	☐	☐	☐
Has the student ever had surgery?	☐	☐	☐
3. Is the student currently taking any prescription or non prescription (over-the-counter) medications or pills or using an inhaler?	☐	☐	☐
Any supplements or vitamins to help weight gain/ weight loss or improve athletic performance?	☐	☐	☐
4. Does the student have any allergies (for example- pollen, medicine, food or stinging insects)?	☐	☐	☐
Has the student ever had a rash or hives develop during or after exercise?	☐	☐	☐
5. Has the student ever passed out during exercise?	☐	☐	☐
Has the student ever been dizzy during or after exercise?	☐	☐	☐
Has the student ever had chest pain during or after exercise?	☐	☐	☐
Does the student get tired more quickly than friends do during exercise?	☐	☐	☐
Has the student ever had racing of their heart or skipped heartbeats?	☐	☐	☐
Has the student ever had high blood pressure or cholesterol?	☐	☐	☐
Has the student ever been told he/she has a heart murmur?	☐	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐	☐
Has any family member or relative been diagnosed with cardiomyopathy (thick heart), long QT Syndrome or Marfan Syndrome?	☐	☐	☐
Has the student had a severe viral infection (for example- myocarditis or mononucleosis) within the past month?	☐	☐	☐
Has a physician ever denied or restricted participation on sports for any heart problems?	☐	☐	☐
6. Does the student have any current skin problems (for example- itching, rashes, acne, warts, fungus or blisters)?	☐	☐	☐
7. Has the student ever had a head injury or concussion?	☐	☐	☐
Has the student ever been knocked out, become unconscious or lost their memory?	☐	☐	☐
Has the student ever had a seizure?	☐	☐	☐
Does the student have frequent or severe headaches?	☐	☐	☐
Does the student ever have numbness or tingling in arms, hands, legs, or feet?	☐	☐	☐
Has the student ever has a stinger, burner or pinched nerve?	☐	☐	☐

	Y	N	?
8. Has the student ever become ill from exercising in the heat?	☐	☐	☐
9. Does the student cough, wheeze or have trouble breathing during or after activity?	☐	☐	☐
Does the student have asthma?	☐	☐	☐
Does the student have season allergies that require medical treatment?	☐	☐	☐
10. Does the student use any special protective or corrective equipment or devices that aren't usually used for their sport or position (for example- knee brace, special neck roll, foot orthotics, retainer on their teeth or hearing aid)?	☐	☐	☐
11. Has the student had any problems with their eyes or vision?	☐	☐	☐
12. Has the student ever had a sprain, strain, or swelling after injury?	☐	☐	☐
Has the student broken or fractured any bones or dislocated any joints?	☐	☐	☐
Has the student had any other problems with pain or swelling in muscles, tendons, bones or joints? Check all that apply.	☐	☐	☐
☐ Head ☐ Elbow ☐ Thigh ☐ Neck			
☐ Forearm ☐ Knee ☐ Back ☐ Wrist			
☐ Shin/Calf ☐ Chest ☐ Hand ☐ Ankle			
☐ Shoulder ☐ Finger ☐ Foot ☐ Hip			
☐ Upper Arm			
13. Does the student want to weigh more or less than they do at the present time?	☐	☐	☐
14. Does the student complain of feeling stressed out?	☐	☐	☐

FEMALES ONLY

15. When was the first menstrual period?_____

When was the most recent menstrual period?_____

How much time usually passes between the start of one period and the start of the next?_____

How many periods has the student had in the past year?_____

What was the longest time between periods in the past year?_____

Explain your answers here:

Completed by _____ Relationship to student _____ Date _____

Print Reset