



**Nebraska Department of Health & Human Services**

**Physical Examination Report**

**Student Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Grade** \_\_\_\_\_

By signing below, the parent/guardian of the above named student consents for the release of the health and medical information contained herein to be released to

\_\_\_\_\_  
(Name of School)

\_\_\_\_\_  
(Signature of Parent/Guardian)

Height:	Weight	
BMI:	BMI Percentile:	
Blood Pressure:	Pulse:	
Physical Findings:	Normal	Abnormal
Appearance		
Ears/Eyes/Nose/Throat		
Lymph nodes		
Heart (note murmur if present)		
Pulses		
Lungs		
Abdomen		
Skin		
Musculoskeletal		
Neck		
Spine/Scoliosis		

\_\_\_ Cleared for participation without restrictions

\_\_\_ Cleared after completing evaluation and/or rehabilitation for:

\_\_\_\_\_

\_\_\_ Not cleared for: \_\_\_\_\_

Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Name of Medical Provider)

\_\_\_\_\_

(Address)

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

(Signature of Medical Provider)

<b>Immunizations received today:</b> ___ DTaP ___ Hep A ___ Hep B ___ HPV ___ Meningococcal ___ MMR ___ Polio ___ Td ___ Tdap ___ Varicella ___ Other (specify): _____
<b>Chronic Conditions:</b> ___ ADD/ADHD ___ Asthma ___ Autism/Asperger's ___ Diabetes Type I, Type II ___ Other: ___ Allergies: _____ ___ Medications: _____  ___ History of Concussions: _____
<b>Results of any lab work done:</b>   

Audiometric Screening					
	500	1000	2000	4000	6000
Right					
Left					

Visual Evaluation	PASS	FAIL	Further eval needed
Amblyopia			
Strabismus			
Internal Eye Health			
External Eye Health			
Visual Acuity	Correction		
20 feet	Right	20/	Yes/No
	Left	20/	Yes/No
16 inches	Right	20/	Yes/No
	Left	20/	Yes/No

NRS 79-214 requires evidence of a physical exam by an MD, PA or APRN within 6 months prior to entrance into Kindergarten, 7th Grade or an out of state transfer student. Vision evaluation is required for within 6 months prior to entrance into Kindergarten or an out of state transfer student. The cost of such physical exam and vision evaluation shall be borne by the parent or guardian of each child who is examined.