

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
Physician Name	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	

PHYSICAL FINDINGS (use back for comments or recommendations)

Height	Weight	Medical	Normal	Abnormal Findings
Blood Pressure	Pulse			
Urinalysis		Appearance	<input type="checkbox"/>	<input type="checkbox"/>
Hemoglobin/Hct		Eyes/ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>
Audiometric Screening Report		Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
		Heart (note murmur if present)	<input type="checkbox"/>	<input type="checkbox"/>
		Pulses (inc. Femoral)	<input type="checkbox"/>	<input type="checkbox"/>
		Lungs	<input type="checkbox"/>	<input type="checkbox"/>
		Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
		Skin	<input type="checkbox"/>	<input type="checkbox"/>
		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
		Neck	<input type="checkbox"/>	<input type="checkbox"/>
		Spine	<input type="checkbox"/>	<input type="checkbox"/>
		Shoulder/arm	<input type="checkbox"/>	<input type="checkbox"/>
		Wrist/hand	<input type="checkbox"/>	<input type="checkbox"/>
		Elbow/forearm	<input type="checkbox"/>	<input type="checkbox"/>
		Hip/thigh	<input type="checkbox"/>	<input type="checkbox"/>
		Knee	<input type="checkbox"/>	<input type="checkbox"/>
		Leg/ankle	<input type="checkbox"/>	<input type="checkbox"/>
		Foot	<input type="checkbox"/>	<input type="checkbox"/>
		Evidence of Scoliosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		Evidence of Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		Stigmata of Marfan's Syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 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