DHHS
Nebraska Department of Health and Human Services

Department of Health and Human Services

Physical Examination Report

Name of School (if desired) York Elementary School

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

SCHOOL VISION EVALUATION
Report Form

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)* [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 @ near (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	Did Not Test
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: _____ ___O.D.
(signature)

Office Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ **Date:** _____