Nebraska Law requires a physical examination prior to entrance into kindergarten, 7th 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/Gardisil (Females Only) #1_____ #2_____ #3_____

Other Immunizations_____

HEALTH HISTORY (Please check Yes or No for each)

Bowel / Bladder Problems ☐ Yes ☐ No Asthma ☐ Yes ☐ No **Meds** _____

Kidney Problems ☐ Yes ☐ No Asthma Action Plan ☐ Yes ☐ No

Hearing Loss ☐ Yes ☐ No Diabetes ☐ Yes ☐ No **Meds** _____

ADHD ☐ Yes ☐ No Meds _____

Allergy to meds ☐ Yes ☐ No Explain Reaction_____

Allergy to food ☐ Yes ☐ No Explain Reaction_____

Other allergies ☐ Yes ☐ No Explain Reaction_____

Diabetes ☐ Yes ☐ No Meds _____

Seizures/Convulsions ☐ Yes ☐ No Explain / **Meds** _____

Concussions / Dates ☐ Yes ☐ No Explain / **Meds** _____

Additional Medications ☐ Yes ☐ 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*

OVER

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 waiver his/her physical and/or vision examination.

*Parent/Guardian Signature*_____ *Date* _____

OVER