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 of HBV)	#1_____	#2_____	#3_____	#4_____		
Hepatitis A	#1_____	#2_____	Meningitis Vaccine		#1_____	#2_____
RotaTeq (Rota Virus Vaccine)	#1_____	#2_____	#3_____			
Varicella (Chickenpox Vaccine)	#1_____	#2_____	Year of Chickenpox Disease		_____	
HPV/Gardisil	#1_____	#2_____	#3_____			

Other Immunications _____

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	_____			
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*

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 SCREENING: P = PASS NP = NOT PASS			
AUDIO TEST @ 20 Dcbs	1000	2000	4000
Right Ear			
Left Ear			

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 receive
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* _____