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

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

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