Department of Health and Human Services

Physical Examination Report

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	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

FH-42 (44042) 4/09