

Falls City Public School Physical Examination Report

New to NE
 Kindergarten
 7th Grade

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. (b) **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 (please request waiver form from school). 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).

Student Name _____ Birthdate ____/____/____ Grade _____ Gender: Male Female

EXAMINATION

Height: _____ Weight: _____ BP: _____ Pulse: _____ Urinalysis: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Medical</th> <th style="width: 33%;">Normal</th> <th style="width: 33%;">Abnormal Findings</th> </tr> </thead> <tbody> <tr><td>Appearance</td><td></td><td></td></tr> <tr><td>EENT</td><td></td><td></td></tr> <tr><td>Lymph Nodes</td><td></td><td></td></tr> <tr><td>Heart (murmur)</td><td></td><td></td></tr> <tr><td>Lungs</td><td></td><td></td></tr> <tr><td>Abdomen</td><td></td><td></td></tr> <tr><td>Skin</td><td></td><td></td></tr> <tr><td>Musculoskeletal</td><td></td><td></td></tr> <tr><td>Neck</td><td></td><td></td></tr> <tr><td>Spine</td><td></td><td></td></tr> </tbody> </table>	Medical	Normal	Abnormal Findings	Appearance			EENT			Lymph Nodes			Heart (murmur)			Lungs			Abdomen			Skin			Musculoskeletal			Neck			Spine		
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<p>IMMUNIZATIONS GIVEN TODAY: Please send record</p> DTP Tdap Polio HIB Hep A Hep B HP Meningococcal MMR Varicella Had chickenpox virus in year _____ Waived for religious military medical reasons (notarized affidavit must be signed to be waived) <i>please attach a copy of immunization record on file</i>																																		
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Vision Acuity</th> <th style="width: 20%;">Pass</th> <th style="width: 20%;">Fail</th> </tr> </thead> <tbody> <tr><td>Amblyopia</td><td></td><td></td></tr> <tr><td>Strabismus</td><td></td><td></td></tr> <tr><td>Internal Eye Health</td><td></td><td></td></tr> <tr><td>External Eye Health</td><td></td><td></td></tr> <tr><td>Visual Acuity</td><td></td><td></td></tr> </tbody> </table> <p> 20 feet: Right 20/____ Left 20/____ with/without correction 16 inches: Right 20/____ Left 20/____ with/without correction Recommend further evaluation by optometrist </p>	Vision Acuity	Pass	Fail	Amblyopia			Strabismus			Internal Eye Health			External Eye Health			Visual Acuity																		
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HEALTH HISTORY

Medications required on daily basis: _____
 Operations _____ Health Conditions _____
 Hearing Problems Seizures: Provide Plan of Care Diabetes: Provide Plan of Care
 ADD ADHD Behavior Diagnosis: _____

ALLERGIES: seasonal environmental medications: _____

Medications Needed at School: _____

Has the allergy ever needed emergency medical treatment? yes no Does the student require an Epi-Pen? yes no

ASTHMA: History of Asthma and requires no current treatment Currently requires treatment as needed for Asthma

Medications Needed at School: _____

Has the asthma ever needed emergency medical treatment? yes no Does the student require an Epi-Pen? yes no

Student is in at least 7th grade and may carry emergency medication on self: Epi-Pen inhaler none.

Provider: Please Check Classification

Regular: Student may participate in the regular physical education, recreation, intramurals, athletics or related activities without undue risk or injury.

Adapted: Student has a condition which may risk sustaining injury from participation in a regular program and has adapted program attached.

Exempt: Students has a severe handicap which might risk sustaining injury from participation in the regular or adapted programs.

Date: ____/____/____ **Physician Signature:** _____

Physicians signature indicates completion of physical exam.

Signature of Guardian: _____

The guardian gives permission for listed medication to be given and/or carried by student/staff of school when appropriate. The guardian gives consent for the release of the health information to be released to the Falls City Public School.