



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	Medical	Normal	Abnormal Findings
Blood Pressure	Pulse			
Urinalysis		Appearance	<input type="checkbox"/>	<input type="checkbox"/>
Hemoglobin/Hct		Eyes/ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>
Audiometric Screening Report		Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
		Heart (note murmur if present)	<input type="checkbox"/>	<input type="checkbox"/>
		Pulses (inc. Femoral)	<input type="checkbox"/>	<input type="checkbox"/>
		Lungs	<input type="checkbox"/>	<input type="checkbox"/>
		Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
		Skin	<input type="checkbox"/>	<input type="checkbox"/>
		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
		Neck	<input type="checkbox"/>	<input type="checkbox"/>
		Spine	<input type="checkbox"/>	<input type="checkbox"/>
		Shoulder/arm	<input type="checkbox"/>	<input type="checkbox"/>
		Wrist/hand	<input type="checkbox"/>	<input type="checkbox"/>
		Elbow/forearm	<input type="checkbox"/>	<input type="checkbox"/>
		Hip/thigh	<input type="checkbox"/>	<input type="checkbox"/>
		Knee	<input type="checkbox"/>	<input type="checkbox"/>
		Leg/ankle	<input type="checkbox"/>	<input type="checkbox"/>
		Foot	<input type="checkbox"/>	<input type="checkbox"/>
		Evidence of Scoliosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		Evidence of Hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
		Stigmata of Marfan's Syndrome	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 feet: Right 20/_____ Left 20/_____ with/without glasses			
16 inches: Right 20/_____ Left 20/_____ with/without glasses			

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

Medication Competency Statement

I, _____ have determined
Parent /Guardian Name

_____ competent to give or apply medication to my child(ren).
Provider/Director

Signature of Parent/Guardian Date

CHILD'S MEDICAL INFORMATION

Any health problems which caregiver should know: _____

Medication, if any: _____

Allergies, if any: _____

Special Concerns: (Glasses, Hearing Aid, Crutches) _____

Any activities child(ren) should NOT engage in: _____

Company providing health and/or accident insurance coverage: (Optional) _____

Certificate of Immunizations

VACCINE	TYPE OF VACCINE	Dose	Normal Schedule	Date Given			DOCTOR OR CLINIC ADMINISTERING
				Mo.	Day	Yr.	
Polio OPV or IPV		1	2 mo.				
		2	4 mo.				
		3	6-18 mo.				
		4	4-6 yrs.				
DTP/DT/DTaP Diphtheria Tetanus Pertussis		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	15-18 mo.				
		5	4-6 yrs.				
Tdap		1	11-18 yrs.				
Td/Tetanus and Diphtheria							
Hib Haemophilus influenzae b		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
M-M-R		1	12-15 mo.				
		2					
Hepatitis A		1					
		2					
Hepatitis B		1					
		2					
		3					
Varicella Chickenpox date of disease		1	12-18 mo.				
		2					
Meningococcal Conjugate		1					
PCV Pneumococcal Conjugate		1	2 mo.				
		2	4 mo.				
		3	6 mo.				
		4	12-15 mo.				
Rotavirus		1	2 mo.				
		2	4 mo.				
		3	6 mo.				

I certify that the above information is correct to the best of my knowledge.

Signature of Parent/Guardian or Physician

Date

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.
Parent or Legal Guardian Signature _____ Date _____

Lincoln Christian School
Dental Examination Report

This is to certify that I have thoroughly examined the teeth of:

(Please print full name of patient)

Please Check ONE:

_____ No dental treatment is necessary at this time.

_____ All necessary dental treatment has been completed.

_____ Dental treatment is scheduled.

Further recommendations:

(Date) (Signature of Dentist)

If you have any questions, please contact the Lincoln Christian School Nurse at 488-8888 x 230.



SCHOOL VISION EVALUATION Report Form

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*) [Nebraska Revised Statute 79-214]

Name: _____ Date of Birth: _____

School: _____ Date: _____

Student Status (*check one*): Beginner Grade Transfer Student from Out of State

REQUIRED TESTS*	Pass	Fail	Recommend Further Evaluation <i>(comments noted below)</i>
Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____
Internal Eye Health	_____	_____	_____
External Eye Health	_____	_____	_____
Visual Acuity			
Right eye @ distance (20 ft.):		20/ _____	aided/unaided
Left eye @ distance (20 ft.):		20/ _____	aided/unaided
Right eye @ near (16 in.):		20/ _____	aided/unaided
Left eye @ near (16 in.):		20/ _____	aided/unaided

**A vision evaluation consisting of these required tests meets the legal requirements for the State of Nebraska but is not a complete eye examination such as most eye doctors perform.*

ADDITIONAL TESTS	Pass	Fail	Recommend Further Evaluation	Did Not Test
Eye Alignment at Distance	_____	_____	_____	_____
Eye Alignment at Near	_____	_____	_____	_____
Depth Perception	_____	_____	_____	_____
Color Vision	_____	_____	_____	_____
Focusing Amount	_____	_____	_____	_____
Focusing Flexibility	_____	_____	_____	_____
Focusing Lag (Accuracy)	_____	_____	_____	_____
Convergence (Crossing) Ability	_____	_____	_____	_____
Saccade (Rapid) Eye Movement	_____	_____	_____	_____
Pursuit (Tracking) Eye Movement	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____

COMMENTS/RECOMMENDATIONS: _____

Evaluation performed by: _____ O.D. ___ M.D. ___ P.A. ___ A.P.R.N.
(signature)

Office Phone Number: (_____) _____ - _____ Date: _____