PHYSICAL EXAMINATION REQUIREMENTS

Health Services Department

Central City Public School

The Board of Education shall require evidence of a physical examination by physician, 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; provided no such examination shall be required of any child whose parent or guardian shall object thereto in writing." A complete visual evaluation is required at the entry grade (kindergarten, or grade of transfer from out of state). A vision professional may also complete the required visual evaluation. Waiver forms are available in each school health office. School Law 79-214 (3).

Each student participating in interscholastic athletics is required to have a complete physical examination (Nebraska School Activities Association requirement) to be given after May 1 of each year. This certifies that the athlete is qualified for the entire school year, May 1 through the following closing day of school, or the current school year.

Name _____ School _____ Grade _____

Address _____ Zip _____ Age _____ Sex: M _____ F ____

Physician _____

PHYSICAL FINDINGS

Height _____ Weight

Blood Pressure _____ Pulse

Urinalysis _____

Hemoglobin/Hct _____

Audiometric Screening Report, if given

	500	1000	20000	4000
RE				
LE				

Immunizations given during today's visit:

DTP__Tdap ____Td____ polio____MMR___ Hib____

Hep B____ Varicella____ other (list)

(Please attach copy of immunization record on file.)

Significant findings/Chronic Health Problems

(please review health history)

MEDICAL	Normal	Abnormal Findings
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart (note murmur if		
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____		

DENTAL EXAMINATION.

This is to certify that the above named student has been in for a regular examination.

Examination: Yes____ No____ Appointment: Yes____ No____

Comments: _____

Dr._____ Date_____

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 re-examined for possible reclassification at the end of the exemption period.

Recommendations: _____

Your signature below indicates completion of physical exam and review of health history.

Date _____ Signed _____, M.D.

Examining Physician (Signature Required)

Clinic/Practice Name *(please print)* _____

Physician Address _____ Physician Phone _____

Return to School Health Office

PLEASE FILL OUT OTHER SIDE

PHYSICAL EXAMINATION REQUIREMENTS
(Preparticipation Medical History)
Health Services Department

Parent or Guardian: Please complete and sign below

Student _____ School _____ Grade _____

Address _____ Zip _____ Age _____ Sex: M ____ F ____

Sport(s) _____

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

	Y	N
1. Has there been a medical illness or injury since the last checkup	☐	☐
2. Has the student ever been hospitalized overnight?	☐	☐
Has the student ever had surgery?	☐	☐
3. Is the student currently taking any prescription or nonprescription		
Is the student currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?	☐	☐
Any supplements or vitamins to help weight gain/weight loss or improve athletic performance?	☐	☐
4. Does the student have any allergies (for example, to pollen, medicine, food or stinging insects)?	☐	☐
Has the student ever had a rash or hives develop during or after exercise?	☐	☐
5. Has the student ever passed out during or after exercise?	☐	☐
Has the student ever been dizzy during or after exercise?	☐	☐
Has the student ever had chest pain during or after exercise?	☐	☐
Does the student get tired more quickly than friends do during exercise?	☐	☐
Has the student ever had racing of their heart or skipped heartbeats?	☐	☐
Has the student ever had high blood pressure or cholesterol?	☐	☐
Has the student ever been told he/she has a heart murmur?	☐	☐
Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
Has any family member or relative been diagnosed with cardiomyopathy (thick heart), long QT Syndrome or Marfan Syndrome?	☐	☐
Has the student had a severe viral infection (for example myocarditis or mononucleosis) within the past month?	☐	☐
Has a physician ever denied or restricted participation in sports for any heart problems?	☐	☐
6. Does the student have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	☐	☐
7. Has the student ever had a head injury or concussion?	☐	☐
Has the student ever been knocked out, become unconscious or lost their memory?	☐	☐
Has the the student nt ever had a seizure?	☐	☐
Does the student have frequent or severe headaches?	☐	☐
Does the student ever have numbness or tingling in arms, hands, legs or feet?	☐	☐
Has the student ever had a stinger, burner or pinched nerve?	☐	☐

	Y	N
8. Has the student ever become ill from exercising in the heat?	☐	☐
9. Does the student cough, wheeze or have trouble breathing during or after activity?	☐	☐
Does the student have asthma?	☐	☐
Does the student have season allergies that require medical treatment?	☐	☐
10. Does the student use any special protective or corrective equipment or devices that aren't usually used for their sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on their teeth or hearing aid)?	☐	☐
11. Has the student had any problems with their eyes or vision?	☐	☐
12. Has the student ever had a sprain, strain or swelling after injury?	☐	☐
Has the student broken or fractured any bones or dislocated any joints?	☐	☐
Has the student had any other problems with pain or swelling in muscles, tendons, bones or joints? (Check which apply.)	☐	☐

☐ Head ☐ Elbow ☐ Thigh
☐ Neck ☐ Forearm ☐ Knee
☐ Back ☐ Wrist ☐ Shin/Calf
☐ Chest ☐ Hand ☐ Ankle
☐ Shoulder ☐ Finger ☐ Foot
☐ Upper arm ☐ Hip

If yes check appropriate box and explain below.

13. Does the student want to weigh more or less than at present?	☐	☐
Does the student lose weight regularly to meet weight requirements for sport?	☐	☐
14. Does the student complain of feeling stressed out?	☐	☐

Explain Yes Answers Here: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. The information provided here may be shared with other school personnel as needed to promote your child's safety and educational success at school.

Signature of parent/guardian _____ Date _____

SCHOOL VISION EVALUATION
Central City Public School
1711 15th Ave.
Central City, Nebraska 68826
School Health Services
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 *(comments noted below)*
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
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: _____ Date: _____
(signature)

____O.D. ____M.D. ____P.A. ____A.P.R.N.

Nebraska Foundation for Children's Vision (www.NEchildrensvision.org)

BACKGROUND INFORMATION FOR PARENTS
REGARDING NEW VISION EVALUATION REQUIREMENT

New State Law Now Requires Vision Evaluations

Beginning with the 2006-2007 school year, students entering school for the first time, including kindergarteners and transfer students from out of state, will be required to provide proof of a vision evaluation within six months prior to the student's entrance.

The vision evaluation is required to test for amblyopia (lazy eye) and strabismus (misalignment of the eyes), which are two of the most common vision disorders in young children, as well as internal and external eye health and visual acuity. A certificate or form stating results of the evaluation must be signed by an optometrist, physician, physician assistant, or advanced practice registered nurse.

According to the Nebraska Foundation for Children's Vision, statistics show that 80% or more of all learning during a child's first 12 years depends on vision, yet one of every five children entering kindergarten has an undetected vision disorder significant enough to impact the child's ability to learn. Symptoms of vision problems often are not evident to parents or educators at early ages, the Foundation notes, and young children often cannot self-identify abnormal conditions.

Typical vision screenings test only for distance vision and are not designed to assess many of the common vision disorders in young children. The new state law will now help assure that more students get a broader assessment of conditions that could adversely impact their learning ability.

Source: Nebraska Foundation for Children's Vision (NEchildrensvision.org)

PARENT/GUARDIAN STATEMENT OF OBJECTION (WAIVER) TO REQUIREMENT FOR VISION EVALUATION

On behalf of my student _____, I object to the required vision evaluation
(Student's Full Name)

as legislated in NSS 79-214. I understand provisions of the law allow me to waive this requirement for my child by my signed statement.

_____ _____

Signature of Parent/Guardian Date

Nebraska Department of Health and Human Services

Department of Health and Human Services
Waiver of Physical Examination/Visual Evaluation Requirement

School Name (if desired)
Central City Public School, Central City, Nebraska

Note to Parent/Guardian: please complete and return to the school health office if you wish to have your child waived from these requirements as allowed by Nebraska law. If you have questions, please contact the school nurse or the school office. Thank you.

As a Parent/Guardian of - Student Name	Student ID#
School Name	Grade

I object to the following requirements for school entry as legislated in Nebraska Revised Statutes 79-214 and 79-220.

Check which apply:

☐ Physical examination by a licensed physician, physician assistant or advance nurse practitioner within six months prior to school entry. *(Applies to: Kindergarten or beginner grade, out of state transfers to any grade, and seventh grade).*

☐ Visual evaluation by a licensed physician, physician assistant, advanced nurse practitioner, or vision professional (optometrist or ophthalmologist) within six months prior to school entry. *(Applies to: Kindergarten or entry grade and out of state transfer to any grade).*

I understand that I may request information to assist me in receiving information about reduced-cost vision examination as required by NRS 79-220.

I understand provisions in the law allow me to waive the requirement for this examination by my signed statement.

SIGN HERE _____ Date _____
Signature of Parent/Guardian

Comments: _____