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	40000
RE				
LE				

Immunizations given during today's visit:

DTP___ Tdap___ Td___Polio___ MMR___Hib___
Hep B___ Varicella___ Other_____
(Please attach a 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)		
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 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_____

PLEASE FILL OUT OTHER SIDE

PHYSICAL EXAMINATION REQUIREMENTS

(Preparticipation Medical History)
Health Services Department

Parent or Guardian: Please complete and sign below

Student Name_____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 check up?	☐	☐
2. Has the student ever been hospitalized overnight?	☐	☐
Has the student ever had surgery?	☐	☐
3. 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/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 student 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 seasonal 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**_____

DENTAL EXAMINATION

Name_____ School_____ Grade_____

Address_____ Zip_____ Age_____ Sex: M_____ F_____

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

Examination: Yes___ No___ Date_____ **Appointment:** Y___ No___ Date_____

Comments:_____

_____

_____

Dr._____ Date:_____
(Dentist Signature)

Please return to Central City Elementary School

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
Ambiyopia	____	____	_____
Strabismus	____	____	_____
Internal Eye Health	____	____	_____
External Eye Health	____	____	_____

Visual Activity

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.*

COMMENTS/RECOMMENDATIONS:

_____

_____

Evaluation performed by: _____ __O.D. __M.D. __P.A. __A.P.R.N
(Signature)

Office Phone Number: _____ **Date:**_____

Waiver of Visual Examination
*I do not wish to obtain a visual examination for my child*_____
(Child's Name)

_____ Date:_____
(Signature of Parent/Guardian)

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

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_____
Signature of Parent/Guardian Date

Comments: _____

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 OPJECTION (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