Kindergarten Physical Examination

_____ Date of Birth_____ Sex_____ Grade_____
Last Name First Name

Address_____ Phone_____ Parent's Name_____
Who to notify in case of an emergency, Name & Phone_____
_____

NEBRASKA LAW requires that each child be protected against measles, mumps, rubella, polio, diphtheria, pertussia, tetanus, and varicella by immunization. Dates for at least 3 DPT, 3 Polio, 2 MMR, 3 Hepatitis B, and 1 varicella must be recorded before a child will be permitted to attend school. (if your child has had the chicken pox, you must list the month/year to be exempt from the vaccine)

IMMUNIZATIONS (Please record dates of immunizations)

DPT_____
DT_____
Tetanus_____
MMR_____
Hepatitis B_____
Polio_____
Tine Test_____
Varicella (Chicken Pox)_____
Other_____

Significant Medical History_____
_____

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Dental Examination

No treatment needed_____ Treatment Needed_____ Treatment Completed_____

Date_____ Signature of Dentist_____

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Physical Examination

(Physician should complete the information below)

General Appearance_____ Height_____ Weight_____
Nutrition and Development _____
Skeletal Development _____
Skin _____
Lymph _____

Head
Eyes _____ Rt._____ Lt._____ With Correction _____
Ears _____ Hearing _____
Nose _____
Mouth/Throat _____

Neck
Thyroid _____

Chest
Heart _____ Size _____ Rate _____ Rhythm _____ BP _____
Lungs _____

Abdomen
Viscerna _____ Hernia _____

Extremities
Upper _____ Lower _____

Neurological
_____

Urinalysis
_____

Remarks and suggestions: _____
_____

_____ _____
Date of Examination Signature of Physician

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 *(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.

Original—Doctor Copy #1—Parent Copy #2—School Nurse Copy #3—Placed in student's permanent file