NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health & Human Services

Physical Exam Report

Immunizations received today:
__ DTaP __ Hep A __ Hep B __ HPV
__ Meningococcal __MMR __ Polio __ Td
__ Tdap __ Varicella
__ Other (specify):

Chronic Conditions:
__ ADD/ADHD
__ Asthma
__ Autism/Asperger's
__ Diabetes Type I, Type II
__ Other:
__ Allergies: ______________________________
__ Medications: ______________________________

__ History of Concussions:

Results of any lab work done:

Audiometric Screening					
	500	1000	2000	4000	6000
Right					
Left					

Vision Evaluation	PASS	FAIL	Further eval needed
Amblyopia			
Strabismus			
Internal Eye Health			
External Eye Health			
Visual Acuity			Correction
20 feet	Right	20/	Yes/No
	Left	20/	Yes/No
16 inches	Right	20/	Yes/No
	Left	20/	Yes/No
Date of Vision Evaluation			
Signature			

NRS 79-214 requires evidence of a physical exam by an MD, PA or APRN within 6 months prior to entrance into Kindergarten, 7th Grade or an out of state transfer student. Vision evaluation is required for within 6 months prior to entrance into Kindergarten or an out of state transfer student. The cost of such physical exam and visual evaluation shall be borne by the parent or guardian of each child who is examined.

Student Name ______________________________
Date of Birth ________________ **Grade** ______

By signing below, the parent/guardian of the above named student consents for the release of the health and medical information contained herein to be released to

Leyton Public Schools
(Name of School)

____
(Signature of Parent/Guardian)

Height:	Weight
BMI:	BMI Percentile:
Blood Pressure:	Pulse:

Physical Findings:	Normal	Abnormal
Appearance		
Ears/Eyes/Nose/Throat		
Lymph nodes		
Heart (note murmur if present)		
Pulses		
Lungs		
Abdomen		
Skin		
Musculoskeletal		
Neck		
Spine/Scoliosis		

__ Cleared for participation without restrictions

__ Cleared after completing evaluation and/or rehabilitation for:

____

__ Not cleared for: ______________________________
Reason: ______________________________
Recommendations: ______________________________
____
____
(Address)

Phone: ______________ Date: ______________

____
(Signature of Medical Provider)