205 E 23rd Street, Scottsbluff, NE 69361

# PHYSICAL EXAMINATION REQUIREMENTS

"The State of NE shall require evidence of a physical examination by a qualified physician 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, provided no such examination shall be required of any child whose parent or guardian shall object thereto in writing." School Law 79-214 (1999)

Name: ____________________ Date of Birth: ______________ Age ________

Parent or Guardian: ____________________________

Address: ___________________________________ Sex: M F

*Doctor's signature is required on second page.*

## MEDICAL HISTORY:

Does the student now have or previously had:

Diabetes ________ Seizures ________ Heart Dise.________ Hearing Loss ________ Asthma ________

Chicken Pox ________ Yr. ________

Does the student have any allergies? ____________________________

Operations or significant injuries (please list) ____________________________

Head injuries ____________________________

Required medication on a daily or episodic routine ____________________________

## PHYSICAL EXAMINATION:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Height | ______ | Ears | ______ | Abdomen | ______ | Musculoskeletal | ______ |
| Weight | ______ | Throat | ______ | Genetalia | ______ | Evidence of Scoliosis | ______ |
| Blood Press. | ______ | Neck | ______ | Skin | ______ | Evidence of Hernia | ______ |
| Pulse | ______ | Lungs | ______ | Posture | ______ | | |
| Eyes | ______ | Heart | ______ | Nutrition | ______ | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Vision | R | ______ | L | ______ | Both | ______ |
| w/glasses | R | ______ | L | ______ | Both | ______ |

Significant finding and remarks: ____________________________

## IMMUNIZATIONS: *(give dates)*

| DPT | | HIB | | DT | | HBV | | Polio | |
|---|---|---|---|---|---|---|---|---|---|
| Series #1 | ______ | Series #1 | ______ | Series #1 | ______ | Series #1 | ______ | Series #1 | ______ |
| Series #2 | ______ | Series #2 | ______ | Series #2 | ______ | Series #2 | ______ | Series #2 | ______ |
| Series #3 | ______ | Series #3 | ______ | | | Series #3 | ______ | Series #3 | ______ |
| Booster #1 | ______ | Booster #1 | ______ | Booster #1 | ______ | | | Booster #1 | ______ |
| Booster #2 | ______ | Booster #2 | ______ | Booster #2 | ______ | | | Booster #2 | ______ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MMR #1 | ______ | Measles | ______ | Rubella | ______ | Varicella #1 | ______ |
| MMR #2 | ______ | Mumps | ______ | TB | ______ | Varicella #2 | ______ |

**Please provide written documentation of the required immunizations listed above. A printed form from your medical provider is acceptable.**

Turn Page Over

Recommendations or Restrictions:________________________________________________________________

________________________________________________________________________________________

Please check classifications:

__________ **Regular**: Student may participate in the regular program of physical education, education, recreation, or related activities.

__________ **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.
Re-examination each year.

It is recommended that a vision exam be done by a Optometrist.

____________________ ________________________________________
Date Examining Physician