

PHYSICAL EXAMINATION REQUIREMENTS

Health Services Department

"The Board of Education shall require evidence of a physical examination by a 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). Physical examinations are recommended at the third and tenth grade in addition to the required examinations. **Annual Blood Pressure and Hemoglobin/Hematocrit are required for E-Cite (Head Start) preschool students.**

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.

For participation in interscholastic athletics, please complete other side.

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	2000	4000
RE				
LE				

Immunizations given during today's visit:

DTP _____ 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 present)		
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 _____	

	PASS	FAIL	RECOMMEND FURTHER EVALUATION (see comments below)
Amblyopia	_____	_____	_____
Strabismus	_____	_____	_____
Internal Eye Health	_____	_____	_____
External Eye Health	_____	_____	_____
Visual Acuity	_____	_____	_____

20 feet: Right 20/____ Left 20/____ with/without glasses
 16 inches: Right 20/____ Left 20/____ with/without glasses

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.

Please check certification

- Certified: Student has passed the physical examination successfully and is physically able to participate in interscholastic athletics.

Activities student should **not** participate in _____

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 _____