Physical Examination Report

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for physical examination in Nebraska schools. No specific form is required by the statute. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success.

By signing below, the parent/guardian of _____ **consents for the**
Name of Student

release of the health and medical information contained herein to be released to _____
Name of School

_____
Signature **Printed Name/Relationship to Student** **Date**

Student Name:	School:	Grade:
	Date of Birth:	Sex: ☐ M ☐ F

Physician Name:

PHYSICAL FINDINGS (use back for comments or recommendations)

Height:	Weight:
Blood Pressure:	Pulse:

Audiometric Screening Report

	500	1000	2000	4000
RE				
LE				

Please attach immunization history/report.

Visual Evaluation Report	PASS	FAIL	Recommend Further Evaluation
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

Medical	Normal	Abnormal Findings
Eyes/ears/nose/throat	☐	☐
Cardiovascular (note murmur if present)	☐	☐
Pulmonary	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Musculoskeletal	☐	☐
	☐	☐
Genital/Urinary Problems ☐ Yes ☐ No ☐ Deferred		

Required medication on a daily or episodic routine:

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:_____

Significant findings/chronic health concerns_____

Your signature below indicates completion of physical exam and review of health history.

Date_____ Signed _____
Examining Physician (Signature Required)

Clinic/Practice Name (please print)_____Physician Phone_____

Physician Address _____

Return to School Health Office when Complete