Student Name _____ **School** _____ **Grade** _____

PHYSICAL EXAMINATION (to be completed by a physician, physician's asst., or nurse practitioner)

Please check box if abnormal and list the abnormality.

Height _____ Weight _____ BP _____

Hearing

Left Ear	Right Ear	Hz
dB	dB	500
dB	dB	1000
dB	dB	2000
dB	dB	4000

Please list any additional information regarding this student that may affect safety or optimal performance in school:

_____

- ☐ Neck _____
- ☐ Eyes _____
- ☐ Lungs _____
- ☐ Ears _____
- ☐ Heart _____
- ☐ Mouth/Teeth _____
- ☐ Abdomen _____
- ☐ Skin _____
- ☐ Spine _____
- ☐ Extremities _____
- ☐ Medications _____

Signature _____ Date _____

(M.D., P.A., or A.P.R.N.)

I do not wish my child to have a physical examination _____

Vison

A School Vision Evaluation is required for all children **within six months prior to entering** Nebraskaschools for the first time *(includes beginner grades including Kindergarteners, transfers, and other students new toNebraska)* [NE revised Statute 79-214]

Required Tests*	Pass/Fail	Recommended Evaluation		
Amblyopia	☐ P ☐ F		Right eye @ Distance (20')	20/ _____ ☐ Aided ☐ Unaided
Strabismus	☐ P ☐ F		Left eye @ Distance (20')	20/ _____ ☐ Aided ☐ Unaided
Internal Eye Health	☐ P ☐ F			
External Eye Health	☐ P ☐ F		Right eye @ Near (16")	20/ _____ ☐ Aided ☐ Unaided
Visual Actuity	☐ P ☐ F		Left eye @ Near (16")	20/ _____ ☐ Aided ☐ Unaided

Signature _____ Date _____

(M.D., O.D., P.A., or A.P.R.N.)

I do not wish my child to have a visual evaluation _____

Date of last dental exam _____ Results _____

Signature _____ Date _____

(Dentist or Parent)