

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 _____

☐ Neck _____

Hearing

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

☐ Eyes _____

☐ Lungs _____

☐ Ears _____

☐ Heart _____

☐ Mouth/Teeth _____

☐ Abdomen _____

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

☐ 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**

(Guardian Signature)

Vision

A School Vision Evaluation is required for all children within six months prior to entering Nebraska schools for the first time (includes beginner grades including Kindergartners, transfers, and other students new to Nebraska) [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**

(Guardian Signature)

Date of last dental exam _____ Results _____

Signature _____ Date _____

(Dentist or Parent)