BOONE CENTRAL SCHOOLS HEALTH EXAMINATION

Physical examination by a physician, physician assistant, or advanced practice registered nurse-nurse practitioner within the 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, is required per Nebraska Department of Health and Human services, Title 173, Chapter 7.

Name:_____ Date of Birth:_____

Gender: MALE FEMALE Grade: K 1 2 3 4 5 6

Height:_____ Weight:_____ HR:_____ B/P:_____

HEALTH HISTORY

☐ ADD/ADHD	☐ Allergies:_____	☐ Asthma
☐ Anxiety/Depression/Mental Health	☐ Developmental Delays	☐ Diabetes
☐Food Intolerance/Lactose/Celiac	☐ Headaches/Migraines/Post Concussion	☐ Seizures
☐Hearing/Vision Impairment	☐ Heart Condition	☐ IBS/Incontinence

Other:_____

IMMUNIZATION RECORD REVIEWED ☐ YES ☐ NO

IMMUNIZATIONS ☐ COMPLETE ☐ INCOMPLETE:_____

VACCINATIONS RECEIVED TODAY:_____

PHYSICAL ACTIVITY

☐ UNRESTRICTED

☐RESTRICTIONS:_____

Comments:_____

Healthcare Provider (print):_____

Healthcare Provider Signature:_____ Date:_____

BOONE CENTRAL SCHOOLS VISION EVALUATION FORM

Visual evaluation by a physician, a physician assistant, an advanced practice registered nurse-nurse practitioner, or an optometrist within six months prior to the entrance of a child into the beginner grade or, in the case of transfer from out of state, to any other grade of the local school, is required per Nebraska Department of Health and Human services, Title 173, Chapter 7.

Name:_____ Date of Birth:_____

REQUIRED TESTS-MUST INCLUDE NEAR VISION TO COMPLY

	Pass	**Fail**
Amblyopia	_____	_____
Strabismus	_____	_____
Internal Eye Health	_____	_____
External Eye Health	_____	_____
Visual Acuity	_____	_____

Right eye @ distance (20 feet): 20/_____ aided / unaided

Left eye @ distance (20 feet): 20/_____ aided / unaided

Right eye @ near (16 inches): 20/_____ aided / unaided

Left eye @ near (16 inches): 20/_____ aided / unaided

COMMENTS:_____

_____

_____

Vision Provider (print):_____

Vision Provider Signature:_____ Date:_____