MINDEN PUBLIC SCHOOLS

Nebraska Law requires a physical /visual examination prior to entrance into kindergarten, 7th grade, and all students transferring into the State of Nebraska.

Name of Student (Last / First / Middle) _____ Birthdate _____ Age _____ Grade _____ School _____

Name of Parent/Guardian _____ Address _____ Phone / Cell Number _____

Family Provider _____ City _____ Family Dentist _____ City _____

IMMUNIZATIONS

DtaP / DTP/Tdap / DT/Td #1_____ #2_____ #3_____ #4_____ #5_____ #6_____

Polio (IPV/OPV) #1_____ #2_____ #3_____ #4_____ #5_____

HIB #1_____ #2_____ #3_____ #4_____

PCV/Prevnar #1_____ #2_____ #3_____ #4_____

MMR / MMRV #1_____ #2_____

Hepatitis B (Hep B or HBV) #1_____ #2_____ #3_____ #4_____

Hepatitis A #1_____ #2_____ Menactra (Meningitis Vaccine) #1_____ #2_____

RotaTeq (Rota Virus Vaccine)) #1_____ #2_____ #3_____

Varicella (Chickenpox Vaccine) #1_____ #2_____ Year of Chickenpox Disease _____

HPV/Gardisil #1_____ #2_____ #3_____

Other Immunizations_____

HEALTH HISTORY (Please check Yes or No for each)

Bowel / Bladder Problems ☐ Yes ☐ No Asthma ☐ Yes ☐ No **Meds** _____

Kidney Problems ☐ Yes ☐ No Asthma Action Plan ☐ Yes ☐ No

Hearing Loss ☐ Yes ☐ No Diabetes ☐ Yes ☐ No **Meds** _____

ADHD ☐ Yes ☐ No Meds _____

Allergy to meds ☐ Yes ☐ No Explain Reaction_____

Allergy to food ☐ Yes ☐ No Explain Reaction_____

Other allergies ☐ Yes ☐ No Explain Reaction_____

Diabetes ☐ Yes ☐ No Meds _____

Seizures/Convulsions ☐ Yes ☐ No Explain / **Meds** _____

Concussions / Dates ☐ Yes ☐ No Explain / **Meds** _____

Additional Medications ☐ Yes ☐ No Explain / **Meds** _____

Family History of Early Cardiac Death Explain _____

Psychiatric/Behavior/Emotional Concerns Explain _____

Surgery / Dates Explain _____

Other Health Problems Explain _____

Additional Information _____

I verify that the above information is correct to the best of my knowledge.

_____

Parent / Guardian Signature *Date*

OVER

MINDEN PUBLIC SCHOOLS

Name of Student (Last / First / Middle) Grade School

PHYSICAL EXAMINATION

(to be completed by a physician, physician's assistant, or nurse practitioner)

Height _____ BMI _____ Mouth/Teeth _____

Weight _____ Lungs _____ Abdomen _____

BP _____ Heart _____ Spine/Scoliosis _____

Pulse _____ Skin _____ Neck _____

Ears _____ Eyes _____ Extremities _____

Urinalysis results _____ Hgb/Hct results _____

Hearing Test (please circle) **Normal / Abnormal**

Left Ear	Right Ear	Hz
dB	dB	500
dB	dB	1000
dB	dB	2000
dB	dB	400

Comments _____

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

_____

Provider's Signature_____ ***Date*** _____

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 Kindergarteners, transfers, and other students new to Nebraska) [NE revised Statute 79-214]

Vision Test (please circle) **Normal / Abnormal**

Required Tests	Pass	Fail	Recommendations	Vision	Glasses / Contacts / Neither
Amblyopia				Right eye @ Far (20')	20 / _____ aided / unaided
Strabismus				Left eye @ Far (20')	20 / _____ aided / unaided
Internal Eye Health					
External Eye Health				Right eye @ Near (16")	20 / _____ aided / unaided
Visual Acuity				Left eye @ Near (16")	20 / _____ aided / unaided

Provider's Signature_____ ***Date*** _____

DENTAL EXAMINATION

Is oral hygiene adequate Yes / No Number of fillings present_____ Number of restorations needed_____

Recommendations: _____

_____

Provider's Signature_____ ***Date*** _____

WAIVER of PHYSICAL, VISION and/or DENTAL EXAMINATION

I, the parent/guardian of _____, do not feel it necessary for he/she to

Name of Child

Have a physical and/or vision & dental examination and therefore exercise my right to waiver his/her physical, vision and/or dental examination. I will not hold Minden Public Schools responsible for any injury or harm caused by or relating to such refusal to obtain a physical, visual or dental evaluation for the above named child.

Parent/Guardian Signature_____ ***Date*** _____