Nebraska Department of Health and Human Services

Department of Health and Human Services

Physical Examination Report

Name of School (if desired)

The school board shall require evidence of (a) a physical examination by a physician, a physician assistant, or an advanced practice registered nurse...within 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; and (b) for school year 2006-07 and each school year thereafter, a visual evaluation by a physician, physician assistant, an advanced practice registered nurse, or an optometrist within six months prior to the entrance of a child into the beginner grade or, in the case of a transfer from out of state, to any other grade of the local school, which consists of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity, except that no such physical examination or visual evaluation shall be required of any child whose parent or guardian objects in writing. The cost of such physical examination and visual evaluation shall be borne by the parent or guardian of each child who is examined. Nebraska Revised Statutes 79-214 (excerpt).

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
Student Address	Zip	Age	Sex: ☐ M ☐ F
Physician Name			

PHYSICAL FINDINGS (use back for comments or recommendations)

Height	Weight
Blood Pressure	Pulse
Urinalysis	
Hemoglobin/Hct	

Audiometric Screening Report

	500	1000	2000	4000
RE				
LE				

Immunizations given during today's visit:
☐ DTP ☐ Td ☐ Polio ☐ MMR ☐ Hib ☐ Hep B ☐ Varicella
☐ Other (list)_____
(Please attach copy of immunization record on file.)

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
Appearance	☐	☐
Eyes/ears/nose/throat	☐	☐
Lymph Nodes	☐	☐
Heart (note murmur if present)	☐	☐
Pulses (inc. Femoral)	☐	☐
Lungs	☐	☐
Abdomen	☐	☐
Skin	☐	☐
Musculoskeletal	☐	☐
Neck	☐	☐
Spine	☐	☐
Shoulder/arm	☐	☐
Wrist/hand	☐	☐
Elbow/forearm	☐	☐
Hip/thigh	☐	☐
Knee	☐	☐
Leg/ankle	☐	☐
Foot	☐	☐
Evidence of Scoliosis	☐ No	☐ Yes
Evidence of Hernia	☐ No	☐ Yes
Stigmata of Marfan's Syndrome	☐ No	☐ Yes

Required medication on a daily or episodic routine:

Please check classification

☐ Regular: Student may participate in the regular program of physical education, recreation, intramurals, athletics or related activities without undue risk or injury.

☐ Adapted: Student has a condition which might risk sustaining injury from participation in the regular program or needs a special adapted program as indicated by the consulting physician. Reexamine each year.

☐ Exempt: Student has a severe handicap which might risk sustaining injury from participation in the regular or adapted programs. These students should be reexamined for possible reclassification at the end of the exemption period.

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

Nebraska Department of Health and Human Services

Department of Health and Human Services
Report of Visual Evaluation

School Name (if desired)

Effective with the 2006-07 school year, Nebraska State Statute 79-214 requires students entering kindergarten (or first grade, if not enrolled in kindergarten) to provide evidence of visual evaluation within six months prior to entry. This requirement also applies to out-of-state transfers to any grade. The vision evaluation may be performed by a physician, physician assistant, advanced practice nurse practitioner, or vision professional (optometrist or ophthalmologist). Students are exempt from this requirement when the parent/guardian provides a written statement of objection. For more information about the vision evaluation requirement, including the availability of resources for low-income families, please contact the school.

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for visual evaluation 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	Student ID#

School

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

Comments:

Signature of Examiner	Date of Exam

Name/Title of Examiner (please print or use stamp)

MEDICATION ADMINISTRATION RECORD

Attention physician/licensed prescribers: If you are faxing this sheet please send to:

East Butler Public Schools Attention: School Nurse Phone 402-545-2081 Fax 402-545-2023

Parent and Physician Request for Administration of Medication at School

_____ is under my care and should receive
(Name)

_____ _____ _____
(Medication) (Dose) (Route) (Frequency)

Adverse Reactions which should be reported to physician: _____

Special Instructions for administration: _____
Known Allergies: _____

Date: _____ **Physician/ Licensed prescriber signature** _____

Parent/ Guardian Signature _____

***SHOULD A CHANGE IN ANY OF THE ABOVE INFORMATION OCCUR, A REVISED WRITTEN PHYSICIAN STATEMENT MUST BE SUBMITTED. MEDICATION MUST BE BROUGHT TO SCHOOL BY AN ADULT, IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST OR PRESCRIBER

****** (below this line is for school use only) ******

Date	Medication/Dose	Number of Tablets	Parent Signature	Nurse Signature

ALL MEDICATIONS MUST BE PICKED UP BY THE END OF THE SCHOOL YEAR OR IT WILL BE DISCARDED

Medication returned: _____ _____ _____ _____
(Date) (# of tabs) (Received by) (Nurse Signature)

East Butler Public Schools 2020-2021
Parent Permission to use Standing Orders
for Medications and Treatments

Student name: _____

GRADE : _____

My child may receive the following medications as needed during the school day:
(Check all that are allowable)

____Tylenol (Acetaminophen) -Every 4 hours as needed for severe headache, toothache, earache or menstrual cramps.
-Liquid dosage according to age/weight for 11 years old and under
-Dosage 1-2 tablets (325 mg each) 12 years or older

____ Advil/Motrin (Ibuprofen) - Every 4 hrs as needed for severe headache, toothache, earache, menstrual cramps or orthopedic injury.
-Liquid dosage according to age/weight for children 3-11 years old.
-1-2 tablets of 200mg ibuprofen for students 12 years or older

____Benadryl (Diphenhydramine) liquid -dose according to age and weight, every 6 hours as needed for allergic reactions.

_____ TUMs/GasX: 1 or 2 tablets every 4 hours as needed for indigestion, upset stomach, nausea or bloating.

_____ Mylanta (liquid antacid) 12 years or older 2-4 teaspoons every 4 hours for heartburn, sour stomach, acid indigestion and symptoms of gas

_____Cough drops 1 drop: every 2 hours as needed for cough, irritation, pain, sore mouth or sore throat for children over 6 years old

_____ Neosporin/ Antibiotic ointment/Burn cream as needed to superficial wounds/abrasions to prevent infection.

_____Hydrocortisone cream or Benadryl (Diphenhydramine) cream to affected area every 2 hours as needed for bug bites or itching related to minor skin irritations.

_____Artificial tears/ Lubricating eye drops 1-2 drops per eye for redness or itching related to allergies or dryness

_____ Orajel (oral pain relief) every 4 hours for sore mouth, toothache, and irritation from orthodontic appliances.

____ Lip Balm/ Vaseline/ other skin protectants– Examples- Aquaphor, Chapstick, Barrier creams

On some or part of days, the school nurse may not be in your child's school building so medication cannot be given under these standing orders.

I understand that if my child uses any of the above listed items on a regular basis (once a week or more, for example), I will be asked to supply the medication from home. Additionally, I understand that my child will only be able to receive these medications subject to the availability of the school nurse.

I understand that First Aid and nursing care for illness and accidents will be provided.

Signature:_____ Date:_____

Please list any known
allergies_____
_____
_____

East Butler Public Schools

Health History
(Preschool through Sixth Grade)

Nebraska Department of Health and Human Services

Student Name_____ Date of Birth_____ Sex: M ☐ F ☐

Parent/Guardian Name:_____ Address:_____

Parent/Guardian Telephone:_____

Parent/Guardian Instructions: The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's safety and educational success. Please contact the school nurse if you have questions. Return the completed form to the school health office.

A. Current Health Status

1. Does your child take medicine or supplements regularly? ☐ No ☐ Yes
   Please list:

2. Does your child have a health condition now under treatment? ☐ No ☐ Yes
   Please list:

3. Does your child currently have allergies? ☐ No ☐ Yes
   Please list:

4. Any concern's about your child's health?

5. Date of last medical exam_____ Dr._____

6. Date of last dental exam_____ Dr._____

7. Does your child have current health insurance coverage? ☐ No ☐ Yes

8. Would you like more information about the state health insurance program? ☐ No ☐ Yes

B. Check conditions your child has experienced and the date.

☐ Sleeping problem_____
☐ Eating problem_____
☐ Coordination problems_____
☐ Tires easily_____
☐ Recurrent headaches_____
☐ Weight problem_____
☐ Eczema_____
☐ Behavior/emotional concerns_____
☐ Hives_____
☐ Chicken Pox_____
☐ Hay Fever_____
☐ Asthma_____
☐ Nosebleeds_____
☐ Blow to the head_____
☐ Broken bones_____
☐ Loss of consciousness_____
☐ Kidney problems/bedwetting_____
☐ Heart problems_____
☐ Diabetes_____
☐ Rheumatic fever_____
☐ Pneumonia_____
☐ Convulsions or seizures_____

C. Illness and Accidents

Please explain each "yes" answer.

1. Has there been more than one ear infection each year? ☐ No ☐ Yes
   Comments:

2. Has there been any hearing problems? ☐ No ☐ Yes
Comments:

3. Has there been a vision problem? ☐ No ☐ Yes
If yes, when were they last fitted for glasses?_____

4. Has your child been hospitalized or had surgery? ☐ No ☐ Yes
If yes, please specify:

D. Previous History

Please explain any "yes" answers.

1. Were there any significant health concerns during pregnancy? ☐ No ☐ Yes
Comments:

2. Was the pregnancy less than nine months? ☐ No ☐ Yes

3. Were there medical problems at birth? ☐ No ☐ Yes
Comments:

4. Birth Weight:_____

5. At what age did your child walk alone?_____

6. At what age did your child say words with meaning?_____

7. Was your child ever enrolled in Early Childhood Special Education or HeadStart? ☐ No ☐ Yes
Date_____ School attended_____

E. Family History

1. List who lives in the home

2. List any family health problems

_____ _____ _____
Completed by Relationship to student Date