Springfield Platteview Community Schools
Health Examination Form

Please Print

Last Name	First Name	Date of Birth	Gender

Street Address	City	State	Zip Code

Phone	School	Grade

Parent(s)/Guardian(s) Name	Name of Physician

Summary of School Immunization Rules and Regulations from the Nebraska Department of Health & Human Services:

Students from Kindergarten through 12th Grade, including all transfer students from outside the State of Nebraska and any foreign students.	• 3 doses of DtaP, DTP, DT, or Td vaccine, one given on or after the 4th birthday • 3 doses of Polio vaccine • 3 doses of pediatric Hepatitis B vaccine or 2 doses of adolescent vaccine if student is 11-15 years of age • 2 doses of MMR or MMRV vaccine, given on or after 12 months of age and separated by at least one month • 2 doses of varicella (chickenpox) or MMRV given on or after 12 months of age. Written documentation (including year) of varicella disease from parent, guardian, or health care provider will be accepted. If the child has had the varicella disease, they do not need any varicella shots.
Additionally, for 7th Grade only	Must be current with the above vaccinations AND receive 1 dose of Tdap (must contain Pertussis booster)

**Exceptions may be made only if the parent/guardian submits an appropriately signed medical or religious waiver informing the school they do not wish their child to be immunized.

Immunizations: Please list month day, and year

DTaP, DTP, DT or Td	Polio	Varicella	Hepatitis B	Pneumococcal
1	1	1	1	1
2	2	2	2	2
3	3	Or Date of Disease	3	3
4	4			4
5			HiB	5
6	MMR	MMRV	1	
	1	1	2	
TD Booster	2	2	3	
1.				

Springfield Platteview Community Schools DO NOT provide vision or hearing screenings for incoming Preschool, Kindergarten, or 7th Grade.

VISION SCREENING: Corrected Y / N

Distance:	**Near:**	
Right Eye ____________________	Right Eye ____________________	Amblyopia ________
Left Eye _____________________	Left Eye _____________________	Strabismus _______

HEARING SCREENING:

Audio Test : 500 1000 2000 4000 Please Check One: Pass _____ Fail _____

Right Ear: ____

Left Ear: ____

PHYSICAL EXAMINATION

Nebraska Law, Section 79-217, requires a physical examination at the time of school entry, at 7th grade, and for all transfer students from out of state. The physical examination must be completed within six months prior to the entrance. Exceptions may be made only if the parent or guardian submits an appropriately signed waiver informing the school that they do not wish their child to have a physical examination. **If the student is participating in sports, the physical must be completed after May 31.**

Height_________ Weight _________ Blood Pressure _________ / _________ Pulse __________ Respiration ___________

	Normal	**Abnormal**	**Comments**
Scalp/Skin	________	_________	____
Heart	________	_________	____
Lungs	________	_________	____
ENT	________	_________	____
Abdomen	________	_________	____
Musculo-skeletal	________	_________	____
Neurological	________	_________	____
Scoliosis	________	_________	____

Additional Comments ____

____

What medications is this child currently taking:

Medications Dose/Frequency

1. ____
2. ____
3. ____

Does or has the child had any of following conditions the school should be aware of?

Condition **Comments**

_____ **Seizure disorders** ____________________

_____ **Diabetes** ____________________

_____ **Urinary conditions** ____________________

_____ **Heart conditions** ____________________

_____ **Eye problems** ____________________

_____ **Ear problems** ____________________

_____ **Speech problems** ____________________

_____ **Behavior/personality problems** ____________________

_____ **Asthma** ____________________

_____ **Allergies:** ____________________

- _____ **Food (if so, what)** ____________________
- _____ **Environmental** ____________________
- _____ **Insect** ____________________
- _____ **Medication (if so, what)** ____________________
- _____ **Other** ____________________

_____ **Other conditions** ____________________

Do any of the above conditions limit: Classroom Activities? Yes _______ No ________
Physical Education? Yes _______ No ________

What are those limitations? ____________________

How long will the limitations be in effect? ____________________

On the basis of this exam, does this child need further referral? (ENT, vision, orthopedic, etc.) Yes_______ No________

If yes, what kind? ____________________

Do you feel the child needs further evaluation (psychological, educational, speech, etc.) Yes _________ No_________

Comments: ____________________

Physician's Signature: ____________________ Date: ____________________

7-12TH GRADE ONLY: SIGNATURE SIGNIFIES THAT THE ATHLETE IS CLEARED TO PARTICIPATE IN SPORTS

Attending Physician (print) ____________________ Office Phone: _________________

Physician's Signature ____________________ Date: ____________________

Signature of Licensed Physician, DO, Physician's Asst., Nurse Practitioner

Medical Release Form

I hereby authorize the release and disclosure of the personal health information of _______________________________ ("student"), as described below, to ____ ("school").

The information described below may be released to the school Principal or Assistant Principal, Athletic Director, Coach, Athletic Trainer, Physical Education Teacher, School Nurse or other member of the school's administrative staff as necessary to evaluate the student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the student which may be released and disclosed includes records of physical examinations performed to determine the student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the school prior to determining eligibility of the student to participate in classroom or other school sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the school by the student's personal physician or physicians; a physician or other health care professional retained by the school to perform physical examinations to determine the student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other healthcare professionals are paid for their services or volunteer their time to the school; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a healthcare provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Principal, School
14801 S. 108th Street Springfield, NE 68059

This authorization will expire when the student is no longer enrolled as a student at the school.

Student Name ____ Date of Birth _______________________

_____ Parent _____Legal Guardian (documentation must be provided)

Signature of Parent/Guardian____

Date __________________________