

| 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 fror | n the Nebraska Dep | artment of Health & Human Se | ervices: |
| 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) | | | |

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 | |
| | 2 | 2 | 3 | |

^{**}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.



| Springfield Platteviev | v Community S | Schools DO NOT pro | ovide vision or hearing so | creenings for incoming P | reschool, Kindergarten, or 7th Grade. |
|--------------------------------------------------------|-------------------------|-----------------------------|-----------------------------|--------------------------|---------------------------------------------------|
| VISION SCREENING Distance: Right Eye | | Near: | | Amblyopia _ | |
| Left Eye | | Left Eye _ | | Strabismus | |
| HEARING SCREENI Audio Test: 500 | | 2000 4000 | Please Check C | one: Pass | Fail |
| Right Ear: | | | | | |
| Left Ear: | | | | | |
| vaiver informing the schoompleted after June 1. Height | ool that they do Weight | | have a physical examination | | ting in sports, the physical must be Respiration |
| neigiit | vveignt | DIUUU P | ressure / | Fulse | Respiration |
| | <u>Normal</u> | <u>Abnormal</u> | <u>Comments</u> | | |
| Scalp/Skin | | | | | |
| Heart | | | | | |
| Lungs | | | | | |
| ENT | | | | | |
| Abdomen | | | | | |
| Musculo-skeletal | | | | | |
| Neurological | | | | | |
| Scoliosis | | | | | |
| Additional Comments | | | | | |
| What medications is the Medications | nis child currer | ntly taking: _Dose/Frequ | Joney | | |
| <u>ivieuications</u> 1. | | Doserriedi | <u>авноў</u> | | |
|) <u>)</u> . | | | | | |
| ··· | | | | | |



| Does or has the child had any of following | g 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 _ Physical Education? Yes No | No |
| What are those limitations? | | |
| | | |
| On the basis of this exam, does this child | d need further referral? (ENT, vision, orthopedic, etc.) | Yes No |
| If yes, what kind? | | |
| Do you feel the child needs further evaluation | ation (psychological, educational, speech, etc.) Yes | No |
| Comments: | | |
| | | |
| Physician's Signature: | | Date: |
| 7-12TH GRADE ONLY: SIGNATURE SI | GNIFIES THAT THE ATHLETE IS CLEARED TO PARTIC | CIPATE IN SPORTS |
| Attending Physician (print) | | Office Phone: |
| Physician's Signature | | Date: |
| Signature of Licensed Physician, DO, Physic | ian's Asst., Nurse Practitioner | |



("student"),

Medical Release Form 2017-2018

I hereby authorize the release and disclosure of the personal health information of _____

| as described below, to | ("school"). |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Trainer, Physical Education Teacher, School Nu | ed to the school Principal or Assistant Principal, Athletic Director, Coach, Athletic rse or other member of the school's administrative staff as necessary to evaluate the ored activities, including but not limited to interscholastic sports programs, physical |
| to determine the student's eligibility to participate Evaluation form or other similar document requir or other school sponsored activities; records of the engaging in school sponsored activities, including | may be released and disclosed includes records of physical examinations performed in school sponsored activities, including but not limited to the Pre-participation red by the school prior to determining eligibility of the student to participate in classroom he evaluation, diagnosis and treatment of injuries which the student incurred while g but not limited to practice sessions, training and competition; and other records as ness to participate in school sponsored activities. |
| physicians; a physician or other health care profestudent's eligibility to participate in certain school such activities, whether or not such physicians or | e may be released or disclosed to the school by the student's personal physician or essional retained by the school to perform physical examinations to determine the I sponsored activities or to provide treatment to students injured while participating in other health care professionals are paid for their services or volunteer their time to the other health care professional who evaluates, diagnoses or treats an injury or other ting in school sponsored activities. |
| · | in writing at any time, except to the extent that action has been taken by a health care ding a written revocation to the school principal (or designee) whose name and address |
| Darin John | nson, Principal, Platteview Central Jr. High School 801 S. 108th Street Springfield, NE 68059 |
| This authorization will expire when the student is | s no longer enrolled as a student at the school. |
| Student Name | Date of Birth |
| ParentLegal Guardian (documen | tation must be provided) |
| Signature of Parent/Guardian | |
| Date | |
| THE STUDENT SHALL NOT | BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS |



Insurance Waiver Form 2017-2018

| Please check all applicable boxes and sign below: | | | | | |
|------------------------------------------------------------------------------------------|-------------------------------------|--|--|--|--|
| We will not purchase the insurance provided by the school to cover our child in i | nterscholastic activities. | | | | |
| Our child is covered by | | | | | |
| Insurance Company | | | | | |
| We will purchase the necessary insurance provided by the school to cover our ch | nild in interscholastic activities. | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Student Name | Date of Birth | | | | |
| | | | | | |
| | | | | | |
| Signature of Student's Parent or Legal Guardian | Date | | | | |

THIS STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL
THIS FORM HAS BEEN SIGNED AND RETURNED TO SCHOOL.