

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 Physic	ian	
Summary of School Immunization Rules	and Regulations from the	ne Nebraska Department	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 Polio vacci 3 doses of pediatric H 2 doses of MMR or MI 2 doses of varicella (c year) of varicella disea 	epatitis B vaccine or 2 doses MRV vaccine, given on or af hickenpox) or MMRV given of	s of adolescent vaccine in ter 12 months of age and on or after 12 months of r health care provider wil	hday f student is 11-15 years of age d separated by at least one month age. Written documentation (including I be accepted. If the child has had the
Additionally, for 7th Grade only	Must be current with the 1 dose of Tdap (must cor	above vaccinations AND red	ceive	

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.



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VISION SCREENIN Distance: Right Eye			Near: Right Eye _			Amblyop	ia	
Left Eye			Left Eye			Strabism	us	
HEARING SCREE Audio Test: 500		2000 -	4000	P	lease Check One:	Pass	_ Fail	
Right Ear:								
Left Ear:								
	hool that they do	not wish th	eir child to ha	ave a phys	•	student is p	nt or guardian submits an appropriate articipating in sports, the physic Respiration	al must b
101g/1t	-				·	_ 1 0.00 _		
					4			
Cooln/Skin	<u>Normal</u>	Abno	<u>rmai</u>	Comme	<u>nts</u>			
·	Normal	ADNO	<u>rmai</u>	Comme	<u>nts</u>			
- Heart	<u>normai</u>	<u>Abnoi</u>	<u></u>	<u>Comme</u>	<u>nts</u>			
Heart Lungs	<u>Normal</u>	<u>Abnoi</u>	<u>rmai</u>	Comme	<u>nts</u>			
Heart Lungs ENT	<u>Normal</u>	<u>ADNO!</u>	<u>mai</u>	<u>Comme</u>	<u>nts</u>			
Heart Lungs ENT Abdomen		Abnoi	rmai		<u>nts</u>			
Heart Lungs ENT Abdomen Musculo-skeletal	<u>Normal</u>	Abnoi	<u></u>	Comme	nts			
Heart Lungs ENT Abdomen Musculo-skeletal Neurological		Abnor	<u></u>		nts			
Heart Lungs ENT Abdomen Musculo-skeletal Neurological Scoliosis								
Scalp/Skin Heart Lungs ENT Abdomen Musculo-skeletal Neurological Scoliosis Additional Comments								
Heart Lungs ENT Abdomen Musculo-skeletal Neurological Scoliosis	this child currer	ntly taking						



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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 Yes _____ No ____ Physical Education? 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_____ If yes, what kind? Do you feel the child needs further evaluation (psychological, educational, speech, etc.) Yes _____ No____ Comments: Physician's Signature: _____ 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