NEBRASKA
Good Life. Great Mission.
DEPT. 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

DENTAL EXAMINATION

Is oral hygiene adequate?_____ Number of fillings present:_____

Number of restorations needed: _____ Date(s) restorations to be completed:_____

Recommendations: _____

Signature: _____DDS Date: _____

SCHOOL VISION EVALUATION

A school Vision Evaluation is required within six months prior to entering Nebraska Schools for the first time (Kindergarten or student transferring from Out of State).

Name: _____ Date: _____

Student Status (check one): _____ Beginner Grade _____ Transfer from Out of State

Required Tests*

	Pass	Fail
Amblyopia		
Strabismus		
Internal Eye Health		
External Eye Health		
Visual Acuity		

Right Eye @ distance (20ft.): 20/_____ aided/unaided
Left Eye @ distance (20ft.): 20/_____ aided/unaided
Right Eye @ near (16ft.): 20/_____ aided/unaided
Left Eye @ near (16ft.): 20/_____ aided/unaided

**A vision evaluation consisting of these required tests meets the legal requirements for the State of Nebraska but is not a complete eye examination such as most eye doctors perform.*

COMMENTS/RECOMMENDATIONS:

_____

_____

Evaluation performed by _____
(Signature)

Office Phone Number: _____ Date: _____

Brodstone
FAMILY MEDICAL CENTER
Superior

NAME: _____

Patient Health Questionnaire-2 (PHQ-2)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____*0*_____+_____+_____+_____+_____

= Total Score _____

Timothy Blecha, MD, ABFP
Jason Hass, PA - C
Heidi Bergen, APRN

Robert Leibel, MD, ABFP
Alisha Fangmeyer, APRN
Teresa Frahm, PMHNP

Julie Theis, MD, ABFP
Matthew Gatlin, PA-C
Amy Rempe, PA-C

525 East 11th St. Superior, NE 68978 | P: 402.879.4781 F: 402.879.3365 | BrodstoneHealthcare.org