SCHOOL DISTRICT OF GRAND ISLAND

Medical Examination by Physician

(Please return this medical exam to the child's school on entrance day)

PHYSICAL FINDINGS:

Skin_____Height_____Weight_____

VISION EVALUATION FORM ON REVERSE SIDE

Ears_____Hearing R_____L_____

Nose_____

Throat_____

Lymphatics_____

Blood_____HGB_____

Urinalysis_____

Heart_____BP_____

Lungs_____

Abdomen_____

Extremities_____

Genitalia_____

Other_____

DENTIST EXAMINATION:

Teeth:

Good_____Caries_____No. Filled_____Gums_____

_____

Date of Examination D.D.S.

Name_____D.O.B._____

Address_____School_____

CERTIFICATION OF IMMUNIZATION

DTaP/DT	Polio	Hepatitis A	Varicella
1	1	1	1
2	2	2	2
3	3	Hib	
4	4	1	Chicken
5	5	2	Pox (yr)
6	Hepatitis B	3	1
MMR	1	4	PPD
1	2	HPV	1
2	3	1	2
Menactra/MCV4		2	3
1		3	4

_____

Date of Examination Signature of Physician

Significant Illnesses:_____

_____

Diagnosis:_____

_____

Any Limitations of Activity:_____

_____

Medications Prescribed:_____

_____

Other Suggestions:_____

_____

_____

STUDENT VISION EVALUATION

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

Name:_____ ID #:_____

Examiner:_____ Date:_____

	Pass	Fail	Recommend Further Evaluation (see comments below)
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/RECOMMENDATIONS

_____

_____