

NORRIS SCHOOL DISTRICT PHYSICAL EXAM FOR SCHOOL ENROLLMENT & ATHLETICS

Norris Public Schools, Nebraska District #160, 25211 S. 68th, Firth, NE 68358

Information for Parents and Guardians

This physical examination form is provided as a convenience to parent/guardian and the student's health care provider in meeting the requirement for physical examination in a Nebraska school. Your physician can also use his/her own exam form as no specific form is required by Nebraska Statute. This form has two sides. Please complete side two of this form, which is your student's health history, plus the release at the top of this side (side 1) of the form.

PARENT/GUARDIAN PLEASE COMPLETE:

Release of Information: By signing below, the parent/guardian of the student named in this physical gives consent for the release of the health information contained herein to Norris School District #160. This document will be stored in the student's school health file.

Parent/Guardian Signature: _____ Date: ____/____/____

Student Name: _____ Date of Birth: ____/____/____ Grade: _____ Male _____ Female _____

Address: _____ City: _____ Zip: _____

PHYSICIAN USE ONLY: PHYSICIAN'S RECORD OF PHYSICAL EXAMINATION

Student's Height: _____ Weight: _____ BP: ____/____ Pulse: _____ Lab Results: Hemoglobin: _____ UA: _____

Hearing:

Vision: *(The exam for the beginner grade or a transfer from out of state must include testing for amblyopia, strabismus, internal/external eye health, and vision acuity.)*

Hz	500	1000	2000	4000
Right dB				
Left dB				

Amblyopia: Pass _____ Fail _____ Strabismus: Pass _____ Fail _____ Comments: _____

Far Acuity: R 20/____ L 20/____ with/without correction Near Acuity: R 20/____ L 20/____ with/without correction

Remaining Medical Exam:	Omitted	Normal	Abnormal	Comments
Eyes/Ears/Nose/Throat:	_____	_____	_____	_____
Thyroid/Nodes/Carotids:	_____	_____	_____	_____
Chest/Lungs/Heart:	_____	_____	_____	_____
Pulses	_____	_____	_____	_____
Abdomen:	_____	_____	_____	_____
Genitourinary:	_____	_____	_____	_____
Skin:	_____	_____	_____	_____
Neurological:	_____	_____	_____	_____
Musculoskeletal:	_____	_____	_____	_____

Immunizations Given During Today's Visit: _____

Athletics/Physical Education Certification: Based upon my examination of this student today, I certify that

_____ this student is cleared for school athletics and physical education without restrictions .

_____ cleared with the following recommendations/interventions: _____

_____ not cleared. Comments: _____

Does this student have your permission to self-administer an emergency medication such as an inhaler or epipen? Prescription is:

_____/_____/_____
Physician's Signature Date Clinic/ Stamp:

