Springfield Platteview Community Schools
Preschool 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 Physician

Summary of School Immunization Rules and Regulations from the Nebraska Department of Health & Human Services:

Ages 2 through 5 years enrolled in a school based program not licensed as a child care provider	4 doses of DTaP, DTP, or DT vaccine 3 doses of Polio vaccine 3 doses of Hib vaccine or 1 dose of Hib given at or after 15 months of age 3 doses of pediatric Hepatitis B vaccine 1 dose of MMR or MMRV given on or after 12 months of age 1 dose 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. 4 doses of pneumococcal or 1 dose of pneumococcal given on or after 15 months of age

**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.

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
3	3	Or Date of Disease	3	3
4	4			4
5			HiB	5
6	MMR	MMRV	1	
	1	1	2	
	2	2	3	

Springfield Platteview Community Schools DOES NOT provide vision or hearing screenings for incoming Preschool students.

VISION SCREENING: Corrected Y / N

Distance:
Right Eye _____
Left Eye _____

Near:
Right Eye _____
Left Eye _____

Amblyopia _____
Strabismus _____

HEARING SCREENING:
Audio Test : 500 1000 2000 4000 Please Check One: Pass _____ Fail _____
Right Ear: _____
Left Ear: _____

PHYSICAL EXAMINATION

Nebraska Law, Section 79-217, requires a physical examination at the time of school entry, at 7th grade, and for all transfer students from out of state. The physical examination must be completed within six months prior to the entrance. Exceptions may be made only if the parent or guardian submits an appropriately signed waiver informing the school that they do not wish their child to have a physical examination.

Height_____ Weight _____ Blood Pressure _____ / _____ Pulse _____ Respiration _____

	Normal	Abnormal	Comments
Scalp/Skin	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
ENT	_____	_____	_____
Abdomen	_____	_____	_____
Musculo-skeletal	_____	_____	_____
Neurological	_____	_____	_____
Scoliosis	_____	_____	_____

Additional Comments

_____

_____

What medications is this child currently taking?

Medications	Dose/Frequency
1.	
2.	
3.	

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 _____
Physical Education? Yes _____ No _____

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_____ No_____
If yes, what kind? _____
Do you feel the child needs further evaluation (psychological, educational, speech, etc.) Yes _____ No_____
Comments: _____

Physician's Signature: _____ Date: _____