Required for students entering Kindergarten, 7th grade, and students from out of state.

Pleasanton Public Schools
Student Health Record

303 W. Church Street
PO Box 190
Pleasanton NE 68866
Phone (308)388-2041
Fax (308)388-5502

Student Name: _____ Grade: _____ DOB: _____/_____/_____

Parent/Guardian: _____ Student Gender: Male_____ Female_____

Address: _____ Phone:_____

PHYSICAL EXAMINATION
(to be completed by a physician, Physician's assistant, or nurse practitioner)

Height _____
Weight _____
BP _____
Pulse _____
Heart _____
Urinalysis results _____

Neck _____
Lungs _____
Eyes _____
Ears _____
Skin _____
Hgb/Hct results _____

Mouth/Teeth _____
Abdomen _____
Spine _____
Scoliosis _____
Extremities _____

Hearing Test (Please Circle) Normal/Abnormal		
Left Ear	**Right Ear**	**Hz**
dB	dB	500
dB	dB	1000
dB	dB	2000
dB	dB	4000

List any additional information regarding this student that may affect safety or optimal performance in school:_____
_____

Provider's Signature _____ Date _____
M.D., O.D., P.S., OR APRN

A School Vision Evaluation is required for all children within six months prior to entering Nebraska schools for the first time (Includes beginner grades including Kindergarteners, transfers, and other students new to Nebraska) [NE revised Statute 79-214]

VISION TEST
(Please circle) Normal / Abnormal

Required Tests	Pass	Fail	Recommendations	Vision	Glasses/Contacts/Neither
Amblyopia				Right eye @ Far (20')	20/_____ aided/unaided
Strabismus				Left eye @ Far (20')	20/_____ aided/unaided
Internal Eye Health					
External Eye Health				Right eye @ Near (16")	20/_____ aided/unaided
Visual Acuity				Left eye @ Near (16")	20/_____ aided/unaided

Provider's Signature _____ Date _____
M.D., O.D., P.S., OR APRN

Waiver of Physical and/or Vision Examination

I, the parent/guardian or _____, do not feel it necessary for he/she to a physical and/or vision examination and therefore exercise my right to waiver his/her physical and/or vision examination.

Parent/Guardian Signature_____ Date _____

Student Name _____ Grade_____

IMMUNIZATIONS

DTAP/DTP/TDAP/DT/TD	#1_____	#2_____	#3_____	#4_____	#5_____	#6_____
POLIO (IPV/OPV)	#1_____	#2_____	#3_____	#4_____	#5_____	
HIB	#1_____	#2_____	#3_____	#4_____		
PCV/PREVNAR	#1_____	#2_____	#3_____	#4_____		
MMR/MMRV	#1_____	#2_____				
HEPATITIS B (HepB or HBV)	#1_____	#2_____	#3_____	#4_____		
HEPATITIS A	#1_____	#2_____				
MENACTRA (Meningitis Vaccine)	#1_____	#2_____				
ROTA TEQ(Rota Virus Vaccine)	#1_____	#2_____	#3_____			
VARICELLA (Chickenpox)	#1_____	#2_____	YEAR OF CHICKENPOX DISEASE _____			
HPV/GARDISIL (Females only)	#1_____	#2_____	#3_____			

Other Immunizations _____

HEALTH HISTORY

Bowel/Bladder Problems	☐YES	☐NO	
Kidney Problems	☐YES	☐NO	
Hearing Loss	☐YES	☐NO	
ADHD	☐YES	☐NO	
Allergy to Meds	☐YES	☐NO	Explain Reaction _____
Allergy to Food	☐YES	☐NO	Explain Reaction _____
Other allergies	☐YES	☐NO	Explain Reaction _____
Diabetes	☐YES	☐NO	Meds _____
Seizures/Convulsions	☐YES	☐NO	Explain/Meds _____
Concussions/Dates	☐YES	☐NO	Explain/Meds _____
Additional Medications	☐YES	☐NO	Explain/Meds _____
Family History of Early Cardiac Death			Explain_____
Psychiatric/Behavior/Emotional Concerns			Explain_____
Asthma	☐YES	☐NO	Meds _____
Asthma Action Plan	☐YES	☐NO	
Diabetes	☐YES	☐NO	Meds _____

Surgery / Dates Explain _____

Other Health Problems Explain _____

Additional Information _____

I verify that the above information is correct to the best of my knowledge.

_____

Parent/Guardian Signature Date