Zion Lutheran School
Christ-Centered, Classical Education

2017-2018 ANNUAL STUDENT HEALTH UPDATE

Please complete, sign and return to school.

Child's Name_____
Grade_____Teacher_____
Parent Name_____
Phone (Home) _____
(Work)_____
Physician_____
Dentist_____Date of last exam_____
Vision Specialist_____Date of last exam_____
Allergies_____
_____

Any life threatening bee sting allergies or food allergies requires a written note from your child's physician with specific instructions for school.

Does your child have any of the following?

Asthma	Yes	No
Heart Conditions	Yes	No
Cerebral Palsy	Yes	No
Hepatitis	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Kidney Problems	Yes	No
Ear Infections	Yes	No
Orthopedic concerns	Yes	No
Emotions concerns	Yes	No

If you answered yes to any of the above, please provide more information about the current problems and management:

_____
_____
_____

Please fill in the name of your child and sign if you agree to the following:
I, as a parent or guardian of _____, give my consent for the School Nurse to contact school staff, who have an "educational need to know", regarding the health status of my child. I understand that all information will be kept confidential

_____
Signature of parent or guardian

This form is required for all students returning to school.

Has your child had a recent injury or illness that might limit him/her in school?

Has your child had any surgeries this past year?
Yes No
If yes, please list:

_____
_____
_____

Has your child ever had ear tubes?
Yes No
Are they still in place Yes No

Does your child have any hearing or vision concerns?
Yes No
If yes, please provide more information

_____
_____
_____

Please list any medication you child will be taking:
At Home

_____
_____
_____

At School

_____
_____
_____

You will be required to complete a medication permission form for your child to take any medication at school. This will be completed for all new medications and each time there is a change in dosage, time, or administration. Medication must be brought in the original labeled container.

Signature of Parent/Guardian _____**Date**_____

Nebraska Department 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