YORK GENERAL
Family Medicine

Revised 6/03

KINDERGARTEN PHYSICAL EXAMINATION FORM

TO PARENTS: It is a prerequisite that your child have a complete physical examination for entrance into Kindergarten. Each child must be protected against Hepatitia B, measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, and tetanus by immunization. Please take this form to your family **doctor, dentist** and **eye doctor** at the time of examination. When completed, please return to the school office.

Name ________________________ School ____________________ Sex ________

Parent or Guardian ______________________________ Date of Birth ______________

DOCTOR'S EXAMINATION

General Appearance Height __________ Weight __________ Nutrition ______________

Tonsils ______________ Adenolds ______________ Hemoglobin __________ or HCT ______

Lungs ______________ B.P. ______________ Urinalysis ______________

Heart ______________ Rate ______________ Hernia __________ Spine ______

Skin ______________ Teeth ______________ Disabilities ______________

N = Normal Do you use seatbelts? ______________ Bike / Roller Blade Helmets? __________

IMMUNIZATION RECORD (Month & Year on each slot)

REQUIRED BY LAW - - LB59 8-24-79

*Required by law

Chicken Pox Disease Date ________

	1st Dose	2nd Dose	3rd Dose	Booster	Booster
DTP/DT	*	*	*		
Polio (OPV/IPV)	*	*	*		
MMR	*	*			
Hepatitis B	*	*	*		
Hib					
Chicken Pox	*				
Prevnar					

T.B. Skin Test .... Neg. .... Pos. .... Date ....

Examining Physician ______________________ M.D./P.A.-C. Date ______________________

Address 2222 N. Lincoln Ave. • York, Nebraska 68467 • 402-362-5555

DENTAL EXAMINATION

No. cavities ______________________ Condition/Teeth ______________________

No. filled ______________________ Condition/Gums ______________________

Dental work complete? ______________ Yes ___ No ___

Examining Dentist ______________________ Date ______________________

SCHOOL VISION EVALUATION

Report Form

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 Kindergartens, transfers, and other students new to Nebraska) [Nebraska Revised Statue 79-214]

Name ______________________ Date of Birth ______________________

School ______________________ Date ______________________

Student Status (check one) ________ Beginner Grade ________ Transfer Student from Out of State

REQUIRED TESTS*	Pass	Fail	Recommend Further Evaluation *(comments noted below)*
Amblyopia	______	______	______________________
Strabismus	______	______	______________________
Internal Eye Heath	______	______	______________________
External Eye Heath	______	______	______________________
Visual Acuity	______	______	______________________

Right eye @ distance (20 ft.):	20/________	aided/unaided
Left eye @ distance (20 ft.):	20/________	aided/unaided
Right eye @ near (16 in.):	20/________	aided/unaided
Left eye @ near (16 in.):	20/________	aided/unaided

** A vision evaluation consisting of these required tests meets the legal requirements for the State of Nebraska but is not a complete eye examination such as most eye doctors perform.*

REQUIRED TESTS*	Pass	Fail	Recommend Further Evaluation *(comments noted below)*
Eye Alignment at Distance	______	______	______________________
Eye Alignment at Near	______	______	______________________
Depth Perception	______	______	______________________
Color Vision	______	______	______________________
Focusing Amount	______	______	______________________
Focusing Flexibility	______	______	______________________
Focusing Lag (Accuracy)	______	______	______________________
Convergence (Crossing) Ability	______	______	______________________
Saccade (Rapid) Eye Movement	______	______	______________________
Pursuit (Tracking) Eye Movement	______	______	______________________
Other ______________	______	______	______________________

COMMENTS/RECOMMENDATIONS ____

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Evaluation performed by ______________________ **Date** ______________________

(signature)