York Medical Clinic, P.C.

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 Hepatitis 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 _____ Adenoids _____ 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 shot)

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: 2114 N. Lincoln Ave., Ste. A • York, NE 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 Kindergartners, transfers, and other students new to Nebraska)* [Nebraska Revised Statute 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 Health		_____	_____	_____
External Eye Health		_____	_____	_____
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.*

ADDITIONAL TESTS	Pass	Fail	Recommend Further Evaluation
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: _____

_____

_____

Evaluation performed by: _____ **Date:** _____

(signature)