

**St. John Lutheran School
Student Health Questionnaire**

Child's Name: _____ Birthday: _____

Parent's Names: _____

1. Pregnancy, Labor, Birth, and first week of life

- A. Did you experience any unusual illness or complications during pregnancy? No ___ Yes ___ - Explain: _____
- B. Child's birth weight _____ lbs. _____ oz. Was your child premature? No ___ Yes ___
- C. Did your baby have trouble during the first week of life? No ___ Yes ___ -circle appropriate terms and explain: blue spells, yellow jaundice, breathing problems, required oxygen, infection, transfusion, birth defect _____

2. Illnesses, allergies, and other problems

- A. Has your child experienced an unusual number of illnesses or other health problems requiring medical care? No ___ Yes ___ -circle appropriate terms: excessive colic, feeding problems, ear trouble/infection, frequent colds, wheezing, vision problems, hoarseness, serious falls, surgical operations, drug reactions, convulsions, foot or leg problems, urinary infections, behavior problems, persistent skin rashes, poisoning, other: _____
Comments: _____
- B. Does your child suffer from allergies of any kind? No ___ Yes ___ (list below, include symptoms)
Medications: _____
Latex: _____
Foods: _____
Other: _____
- C. Has your child had any of the following diseases: (circle all that apply) "Red" or "hard" measles (rubeola), German or 3-day measles (rubella), meningitis, chicken pox, scarlet fever, rheumatic fever, mumps, pneumonia, diabetes, streptococcal infections, fever 104°F for more than 2 days.
Comments: _____

3. Development

- A. So far as you know, is your child's development normal? No ___ Yes ___
- B. When did he/she: Sit alone? _____ Stand alone? _____ Take 10 steps alone? _____

4. Family History

- A. Is this child's father living? No ___ Yes ___ In good health? No ___ Yes ___
Is this child's mother living? No ___ Yes ___ In good health? No ___ Yes ___
- B. Number of other children living in the home _____ Ages _____
Are they in good health? No ___ Yes ___ Comments: _____
- C. Have there been any major changes in the family situation in the last year, such as family moving, loss of someone close, divorce, marriage, or a serious illness of either parent? No ___ Yes ___
Comments: _____
- D. Do any family members have a history of diabetes, hay fever, convulsions, tuberculosis, migraines, or asthma? (Circle all that apply)
- E. Is there smoking in the home? No ___ Yes ___
- F. Does your child normally eat breakfast? No ___ Yes ___
- G. Child usually sleeps _____ hours each night.
- H. The usual bedtime is _____
- I. Name of child's doctor _____
- J. Name of child's dentist _____ Date of last visit _____

5. Medications

- A. Is your child currently taking any medications? No ___ Yes ___
- B. List all medications: _____



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
Physician Name		Sex: <input type="checkbox"/> M <input type="checkbox"/> F

PHYSICAL FINDINGS (use back for comments or recommendations)

Height	Weight	Medical	Normal	Abnormal Findings
Blood Pressure	Pulse			
Urinalysis		Appearance	<input type="checkbox"/>	<input type="checkbox"/>
Hemoglobin/Hct		Eyes/ears/nose/throat	<input type="checkbox"/>	<input type="checkbox"/>
Audiometric Screening Report		Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
		Heart (note murmur if present)	<input type="checkbox"/>	<input type="checkbox"/>
		Pulses (inc. Femoral)	<input type="checkbox"/>	<input type="checkbox"/>
		Lungs	<input type="checkbox"/>	<input type="checkbox"/>
		Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
		Skin	<input type="checkbox"/>	<input type="checkbox"/>
		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
		Neck	<input type="checkbox"/>	<input type="checkbox"/>
		Spine	<input type="checkbox"/>	<input type="checkbox"/>
		Shoulder/arm	<input type="checkbox"/>	<input type="checkbox"/>
		Wrist/hand	<input type="checkbox"/>	<input type="checkbox"/>
		Elbow/forearm	<input type="checkbox"/>	<input type="checkbox"/>
		Hip/thigh	<input type="checkbox"/>	<input type="checkbox"/>
		Knee	<input type="checkbox"/>	<input type="checkbox"/>
		Leg/ankle	<input type="checkbox"/>	<input type="checkbox"/>
		Foot	<input type="checkbox"/>	<input type="checkbox"/>
		Evidence of Scoliosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		Evidence of Hernia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		Stigmata of Marfan's Syndrome	<input type="checkbox"/> No <input type="checkbox"/> Yes	

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internal Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
External Eye Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 feet: Right 20/_____ Left 20/_____ with/without glasses			
16 inches: Right 20/_____ Left 20/_____ with/without glasses			

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

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 Kindergarteners, 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 <i>(comments noted below)</i>
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	Did Not Test
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: _____ O.D. ___ M.D. ___ P.A. ___ A.P.R.N.
(signature)

Office Phone Number: (_____) _____ - _____ Date: _____