HEALTH INFORMATION FOR PARENTS

What does Nebraska state law require for my child to enter school?

- RECORD OF IMMUNIZATIONS to include a minimum of:
  -3 doses of Dtap, DTP, or DT vaccine with one given on or after **4th birthday.**
  -3 doses of Polio vaccine
  -2 doses of MMR or MMRV vaccine
  -3 doses of Hepatitis B vaccine
  -2 doses of Varicella (chickenpox) vaccine or MMRV or signed Documentation of Varicella Disease form
- A PHYSICAL EXAM done within 6 months prior to entrance date
- CERTIFIED COPY OF BIRTH CERTIFICATE. It must have the raised, embossed seal.

What else do I need to do before my child enters school?

- A VISUAL EVALUATION by a physician, a physician assistant, advanced practice registered nurse, or an optometrist within 6 months prior to entrance date. This visual exam is to consist of testing for amblyopia, strabismus, and internal and external eye health, with testing sufficient to determine visual acuity.
- A DENTAL EXAM is not required by law but is recommended. Please have your dentist complete the form and return it to school in the fall.
- HEALTH RECORD. Please complete and leave at school. Please note any health problems or diseases we need to be aware of at school, such as: asthma, vision, ear, bladder, heart or skin problems, allergies, or any other problems that we need to be aware of. Your child will be spending the greater part of his/her day with us during the school year, and we feel a great responsibility for our students while they are under our care.

What if my child needs to be given medication at school?

- Medications are strongly discouraged from being given at school. If at all possible, try to give them at home. (Example: An antibiotic ordered to be given four times a day could be given before and after school, after the evening meal, and at bedtime.)
- If a **prescription** medication needs to be given at school, we will first need an authorization form signed by the physician and parent. The medication also needs to be in a prescription bottle. Ask your pharmacist for an extra labeled bottle at the time your prescription is filled.
- If a **non-prescription** medication needs to be given at school, we will also need a permission form completed by the parent. The medication needs to be in the original container it came in.
- Medication authorization forms can be found at the back of the student handbook or obtained from the school.

What are the school guidelines if my child gets a communicable disease?

- We follow the Nebraska Department of Health and Human Services guidelines for contagious and infectious diseases.
- **Chickenpox** – Excluded for at least 5 days after the eruption first appears or until vesicles become dry.
- **Conjunctivitis (pinkeye)** – Child will be sent home from school if symptoms noted and may return to school 24 hours after treatment is initiated or at administrative/school staff discretion.
- **Head lice** – Excluded from school until treatment has been completed. Child may return to school the day following treatment with special shampoo. It is essential that all nits (lice eggs) be removed before the child returns to school. Treatment needs to be repeated in 7 to 10 days. Head lice are nothing to be ashamed about. Anyone can get them.
- **Impetigo** – Excluded from school until antibiotic ointment applied to the affected area.
- **Ringworm** – Fungal infection appearing as scaly oval lesions of the skin. Child is excluded until treatment is started.
- **Scabies** – Infection caused by an almost invisible mite that burrows under the skin and causes severe itching especially in the finger webs, elbows and crotch. Child is excluded until the day after treatment is started.
- **Please notify the school if your child has any communicable disease so we can check the entire class and prevent an epidemic.**

Illness Guidelines and Recommendations from the School Nurse

- If your child hasn't felt well the evening before or has had a sore throat, cough, fever, vomiting or diarrhea, please keep them home 24 hours to avoid classroom epidemics.
- If a child comes to the nurse's office complaining of not feeling well and has a temperature of 100 degrees or higher or has vomited, we will ask you to get your child from school.
- Be sure your child is better before they return to school.
- Please send a note to your child's teacher if they have been ill so the teacher might better understand if your child is not their "usual self" when they return to school.

KINDERGARTEN HEALTH RECORD

Student's Name_____Grade_____
Family Doctor_____Phone_____
Family Dentist_____Phone_____
Family Eye Doctor_____Phone_____

Circle One

1. Does your child take any medication regularly? If yes, please list medication(s) and why prescribed_____ Yes No

_____

3. Is your child currently under a doctor's care for any condition?_____ Yes No

_____

3. Does your child have asthma or other respiratory problems?_____ Yes No
4. Is your child allergic to any food or insect bites?_____ Yes No
5. Has your child ever developed hives when they have eaten a food or been stung by an insect?_____ Yes No
6. Does your child have any other type of allergies?_____ Yes No

_____

7. Has your child ever had a surgical operation?_____ Yes No

_____

8. Has your child ever had a seizure?_____ Yes No

_____

9. Does your child have any heart problems and if so, are there activity restrictions? Yes No

_____

10. Does your child have any bladder or bowel problems?_____ Yes No

_____

11. Does your child have any vision or hearing problems?_____ Yes No

_____

12. Has your child ever had the chicken pox? If yes, what year?_____ Yes No
13. Has your child been examined by a dentist in the past year? Yes No
14. Has your child been examined by an eye doctor in the past year? Yes No
15. Child's weight at birth_____Premature?_____Any problems at birth?_____

_____

Please write any other information you feel we may need concerning your child's health.

_____

_____

_____

Parent Signature_____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

FH-42 (44042) 4/09

Nebraska Department of Health and Human Services

Department of Health and Human Services
Report of Visual Evaluation

School Name (if desired)

Effective with the 2006-07 school year, Nebraska State Statute 79-214 requires students entering kindergarten (or first grade, if not enrolled in kindergarten) to provide evidence of visual evaluation within six months prior to entry. This requirement also applies to out-of-state transfers to any grade. The vision evaluation may be performed by a physician, physician assistant, advanced practice nurse practitioner, or vision professional (optometrist or ophthalmologist). Students are exempt from this requirement when the parent/guardian provides a written statement of objection. For more information about the vision evaluation requirement, including the availability of resources for low-income families, please contact the school.

PARENT/GUARDIAN: This form is provided as a convenience to you and your child's health care provider in meeting the requirement for visual evaluation 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 | Student ID#

School

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

Comments:

Signature of Examiner | Date of Exam

Name/Title of Examiner (please print or use stamp)

Nebraska Department of Health and Human Services

Department of Health and Human Services
Waiver of Physical Examination/Visual Evaluation Requirement

School Name (if desired)

Note to Parent/Guardian: please complete and return to the school health office if you wish to have your child waived from these requirements as allowed by Nebraska law. If you have questions, please contact the school nurse or the school office. Thank you.

As a Parent/Guardian of - Student Name	Student ID#
School Name	Grade

I object to the following requirements for school entry as legislated in Nebraska Revised Statutes 79-214 and 79-220.

Check which apply:

☐ Physical examination by a licensed physician, physician assistant or advance nurse practitioner within six months prior to school entry. *(Applies to: Kindergarten or beginner grade, out of state transfers to any grade, and seventh grade).*

☐ Visual evaluation by a licensed physician, physician assistant, advanced nurse practitioner, or vision professional (optometrist or ophthalmologist) within six months prior to school entry. *(Applies to: Kindergarten or entry grade and out of state transfer to any grade).*

I understand that I may request information to assist me in receiving information about reduced-cost vision examination as required by NRS 79-220.

I understand provisions in the law allow me to waive the requirement for this examination by my signed statement.

SIGN HERE_____

Signature of Parent/Guardian Date

Comments: _____