MEDICAL RECORD FORM
Fairbury Public Schools

NAME: _____

(Last) (First) (Middle) (Birthdate) (Telephone)

_____ _____

Parent/Guardian Name Address

_____ _____

Family Physician Telephone Family Dentist Telephone

HISTORY (*To be completed by Parent*)

ALLERGIES: _____

OTHER: _____

BEHAVIOR HABITS: ("X" If Applies)

- Speech difficulties _____
- Bed Wetting _____
- Disturbed Sleep _____
- Nail Biting _____
- Finger Sucking _____
- Temper Tantrums _____
- Poor Eating Habits _____
- Mouth Breathing _____
- Contact W/Tuberculosis ____

o, When _____

m Whom _____

- Operations _____
- Heart Conditions _____
- Routine Medications _____

Diseases: ("X" if Applies and Date)

Diabetes _____
Asthma _____
Ear Aches _____
Sore Throat _____
Headaches _____
Gastrointestinal Disturbance _____
_____
Epilepsy _____

Scarlet Fever _____
Meningitis _____
Chicken Pox _____
Pneumonia _____
Bronchitis _____
Rheumatic Fever _____
Joint Pain _____
Convulsions _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Posture: _____ Nutrition: _____ B/P: _____ P: _____

Skin: _____ Eye Symptoms: _____

Eyes: Inspection R _____ Visual Acuity: R _____

L _____ L _____

Ears: Discharge R _____

L

Nose:_____ Tonsils:_____ Adenoids: _____ Glands:_____

Thyroid: _____ Heart: _____ Lungs:_____ Abdomen: _____

Hernia:_____ Genitals: _____

Nervous Symptoms: _____ Extremities:_____

Medical Care Advised: _____

*** LABORATORY (Kindergarten & 7th Grade – REQUIRED)** Urinalysis _____

*** My signature indicates student needs no further screenings at school this year***

Date: _____ Examining Physician: _____

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 such as Kindergarten, transfers, and other students new to Nebraska) [Nebraska Revised Statute 79-214]

Name: _____ Date of Birth: _____

School: _____

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**	**Did Not Test**
Eye Alignment @ Distance	_____	_____	_____	_____
Eye Alignment @ 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/RECOMMENDATION: _____

_____

** My signature indicates student needs no further screenings at school this year***

Evaluation performed by: _____ ___ O.D. ___ M.D. ___ P.A. ___ A.P.R.N.

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