



# Bellevue Public Schools

*"Proudly serving the Bellevue/Offutt Community"*

**B**

NRS 1047-6/10

## PHYSICAL EXAMINATION

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Last Name First Name Birthdate  M  F Grade

**PHYSICAL EXAM:** Blood Pressure \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Pulse \_\_\_\_\_ Respirations \_\_\_\_\_

General Appearance \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Nutritional Status \_\_\_\_\_ Hematocrit or Hgb. \_\_\_\_\_ Urinalysis \_\_\_\_\_

Skeletal Development/Posture \_\_\_\_\_ Scoliosis \_\_\_\_\_

Scalp and Skin \_\_\_\_\_ Lymph Nodes \_\_\_\_\_ Neck \_\_\_\_\_

Ears \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_

Mouth \_\_\_\_\_ Teeth and Gums \_\_\_\_\_ Speech \_\_\_\_\_

Heart \_\_\_\_\_

Lungs \_\_\_\_\_ Tuberculin Skin Test: Positive \_\_\_\_\_ Negative \_\_\_\_\_

Abdominal examination \_\_\_\_\_ Hernia \_\_\_\_\_

Extremities. Upper \_\_\_\_\_ Extremities. Lower \_\_\_\_\_

Neurological exam \_\_\_\_\_

**HEALTH HISTORY:** Check any past or present illness of this child the school should be made aware of, such as:

- |  |  |
|--|--|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> hepatitis           |
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> kidney infections   |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> physical handicaps  |
| <input type="checkbox"/> Chicken Pox _____     | <input type="checkbox"/> seizure disorder    |
| <input type="checkbox"/> Diabetes Year _____   | <input type="checkbox"/> serious injuries    |
| <input type="checkbox"/> Heart disease         | <input type="checkbox"/> surgical operations |
| <input type="checkbox"/> Other (specify) _____ |  |

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						
HEARING SCREENING: Pass Fail						
Audio Test	500	1000	2000	4000	6000	8000
Right Ear						
Left Ear						
IMPEDANCE: Right Ear Left Ear						

1. Is this child subject to any illness which may result in a classroom emergency? Yes ( ) No ( )  
 If yes, please describe: \_\_\_\_\_

2. Is this child subject to any condition which limits: Classroom activities? Yes ( ) No ( )  
 Physical education? Yes ( ) No ( )  
 Competitive sports? Yes ( ) No ( )  
 If yes, please describe: \_\_\_\_\_

3. Is this child taking any medication? ( ) Yes ( ) No If yes, please identify, etc: \_\_\_\_\_

4. Any other remarks or suggestions? \_\_\_\_\_

Signature of Health Care Provider

Stamp Required

Date of Exam