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 ______________
om 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: _________________________