Meridian Public School
MEDICAL RECORD FORM

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

_____ _____
Parent / Guardian Name Parent / Guardian Address

_____ _____
Family Physician Telephone # Family Dentist Telephone #

HISTORY (To be completed by Parent)

ALLERGIES _____

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 _____

Diseases (place an "x" by those child has had, give dates)
Diabetes _____
Asthma _____
Ear aches _____
Sore throat _____
Headaches _____
Gastro-intestinal disturbance _____
Epilepsy _____
when _____

Scarlet fever _____
Meningitis _____
Chicken pox _____
Pneumonia _____
Bronchitis _____
Rheumatic fever _____
Joint pain _____
Convulsions _____
from whom _____

Operations _____
Heart condition _____ Routine medications _____

PHYSICAL EXAMINATION (To be completed by Doctor)

Height _____ Weight _____ Posture _____ Nutrition _____ B/P _____
Skin _____ Eye symptoms _____
Eyes: Inspection R _____ Visual Activity R _____
L _____ L _____
Ears: Discharge R _____ Hearing R normal _____ dull _____
L _____ L normal _____ dull _____
Nose _____ Tonsils _____Adenoids _____ Glands _____
Thyroid _____ Heart _____ Lungs _____ Abdomen _____
Hernia _____ Genitals _____
Nervous symptoms _____ Extremities _____
Medical care advised: _____

LABORATORY (Required) (Optional)
Urinalysis _____ Tine or PPD test for tuberculosis _____
Follow-up if positive _____
Date _____ _____M..D.
(Examining Physician)

DENTAL EXAMINATION (To be completed by Dentist)

Restoration needed? _____ Restoration completed _____
Is Oral Hygiene adequate? _____ Recommendations _____
Date _____ _____D.D.S.
(Examining Dentist)

Immunizations:
DPT/DTaP/Td 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Polio 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
MMR 1. _____ 2. _____
HIB 1. _____ 2. _____ 3. _____ 4. _____
Hep B 1. _____ 2. _____ 3. _____
Varicella (Chicken Pox) _____ Had Disease / Date _____

A School Vision Evaluation is required for all children within six months prior to entering Nebraska schools for the first time *(included 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 (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 ft.)			20/_____ aided / unaided
Left eye @ near (16 ft.)			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 (comments noted below)
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	_____	_____	_____

COMMENTS/RECOMMENDATIONS: _____

_____

_____

Evaluation performed by: _____ Date: _____
(signature)

___O.D. ___ M.D. ___P.A. ___ A.P.R.N.

Original – Doctor Copy #1 – Parent Copy #2 – School Nurse Copy #3 – Placed in student's permanent file
Nebraska Foundation for Children's Vision (www.NEchildrensvision.org)