111 North Dewey St. Suite A
North Platte, Nebraska 69101
Business (308)696-1201
Fax (308)696-1204
www.wcdhd.org

Physical Exam Checklist

This information is being sent to you for your school's upcoming school related exam on the July 22, 2019 event located at the Arthur Co. School. Please review the attached "Physical Exam Report", "Dental Screening Report Card" and the "Patient Encounter form". If you have any questions about this information, please call us at (308) 696-1201 Opt 2

FORMS: Please complete the top section of the Department of Health & Human Services "Physical Exam Report" and the "Patient Encounter" prior to your examination.

Urine specimens will be collected on site for Kindergarten physicals. For some younger children this can be overwhelming, ensuring the child has plenty of fluids prior to the visit will help in the clean-catch collection.

The following chart provides information on the **DHHS minimum statute requirements** for entry into School. Highlighted below are the areas West Central District Health Department can provide on the July 22, 2019 event located at the Arthur Co. School.

EFFECTIVE JUNE 10, 2017
OPERATIVE JULY 1, 2017

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

173 NAC 7

ATTACHMENT 1: DHHS MINIMUM REQUIRED ANNUAL SCHOOL HEALTH SCREENINGS

SCREENING by Grade or Age Level *For procedural guidelines and competencies for each screening, see DHHS School Health Guidelines for Nebraska Schools.*	**Age 3-5 yrs**	**K**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
HEARING: pure tone audiometry	**annually**	X	X	X	X	X			X			X		
VISION: distance	**annually**	X	X	X	X	X			X			X		
VISION: hyperopia (near vision)	**annually**	x	X	x	X	x								
DENTAL: inspection of teeth	**annually**	X	X	X	X	X			X			X		
HEIGHT/WEIGHT measurement	**annually**	X	X	X	X	X			X			X		
Physical Examination *By physician, physician assistant, or advanced practice registered nurse*		X							X					
Visual Evaluation *By physician, physician assistant, advanced practice registered nurse, or optometrist.*		X												

Additional Indications for Screening:

1. New to district at any time, with no previous screening results available.
2. Student enters the Student Assistance Process, with no recent or current screening results available.
3. Periodic screenings as specified by the student's Individualized Education Plan (IEP)
4. Nurse concern, i.e. sudden wt. loss/gain, change in stature or appearance; parent or teacher concern; audiologist referral.
5. Unremediated concerns from previous year.

Notes:

1. The student with known hearing or vision deficits may not need periodic screenings for these conditions. This will be determined on an individual basis by the child's Individualized Education Plan (IEP) and/or school personnel following the student.
2. Screening results may be taken from physical examination, visual evaluation, or dental examination reports if equivalent screening results are available and documented.
3. If parent/guardian wishes to refuse school health screening, parents/guardian must submit written statement(s) from a qualified examiner that the child has received the minimum required screenings within the past six months or the child will be screened at school.

Kindergarten Required Vaccines: 1. **Dtap**: diphtheria, tetanus and pertussis is the 5th and final dose of the pediatric series, 2. **Polio**: IPV vaccine is the fourth and final dose in the series, 3. **MMR**: Mumps, measles and rubella is the second and final dose of this vaccine, 4. **Chicken Pox vaccine** (Varivax) second and last doses of the series. Parent presence and consent required.

7th Grade Required Vaccines: 1. **Tdap**: tetanus, diphtheria, and pertussis. 2. **Meningococcal:** first dose in the series. 3. **HPV**: first dose of the series. Parent presence and consent required.

Please contact our office with any questions (308) 696-1201 Opt. 2

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Sports/School Physicals

July 22nd, 2019

Arthur County School

9:00 am to 12:00 pm MST

Don't miss out! Beat the back-to-school rush!

WHO MUST BE EXAMINED?

- Children entering Kindergarten and 7th grade
- Children new to Nebraska
- Children involved in sports activities (annual requirement)

WHAT IS PROVIDED IN THE EXAM?

- Physical Examinations/Sports Physicals (if required)

WHY DOES MY CHILD NEED TO BE EXAMINED?

- Annual sports physicals are required for athletes
- School requirement (Neb. Rev. Stat. § 79-214)

HOW DO I SCHEDULE AN APPOINTMENT?

- Call 308-221-6831 or
- Come to Arthur County School between 9:00 am and 12:00 pm MST on July 22nd, 2019

HOW MUCH DOES THE EXAM COST?

- If your child's services are covered by insurance, no upfront cost to you. Their visit will be billed as their annual physical/well-child check.
- If the child does not have insurance coverage, the cost will be:
  - **$50.00 - Kindergarten & 7th Physicals (**if your child participates in organized sports, sport physical is included in cost)
  - **$40.00 - Sports Physicals only**

  ****multiple children uninsured, $10.00 off each additional child**

ADDITIONAL SERVICES PROVIDED BY REQUEST

- Immunizations (parent consent and presence required, please provide copy of your child's current immunization record)
- Dental: Inspection of teeth - $5 charge

For individual details on additional services contact our office @ (308)696-1201 opt. 2.

PLEASE PROVIDE A COPY OF INSURANCE CARDS

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health & Human Services

Physical Exam Report

Immunizations received today:
__ DTaP __ Hep A __ Hep B __ HPV
__ Meningococcal __MMR __ Polio __ Td
__ Tdap __ Varicella
__ Other (specify):

Chronic Conditions:
__ ADD/ADHD
__ Asthma
__ Autism/Asperger's
__ Diabetes Type I, Type II
__ Other:
__ Allergies: _____
__ Medications: _____

__ History of Concussions:

Results of any lab work done:

Audiometric Screening					
	500	1000	2000	4000	6000
Right					
Left					

Vision Evaluation			Further eval needed
Amblyopia			
Strabismus			
Internal Eye Health			
External Eye Health			
Visual Acuity			Correction
20 feet	Right	20/	Yes/No
	Left	20/	Yes/No
16 inches	Right	20/	Yes/No
	Left	20/	Yes/No
Date of Vision Evaluation			
Signature			

NRS 79-214 requires evidence of a physical exam by an MD, PA or APRN within 6 months prior to entrance into Kindergarten, 7th Grade or an out of state transfer student. Vision evaluation is required for within 6 months prior to entrance into Kindergarten or an out of state transfer student. The cost of such physical exam and visual evaluation shall be borne by the parent or guardian of each child who is examined.

Student Name_____
Date of Birth _____ **Grade** _____
By signing below, the parent/guardian of the above named student consents for the release of the health and medical information contained herein to be released to
Arthur County School
(Name of School)

_____
(Signature of Parent/Guardian)

Height:	Weight	
BMI:	BMI Percentile:	
Blood Pressure:	Pulse:	
Physical Findings:	Normal	Abnormal
Appearance		
Ears/Eyes/Nose/Throat		
Lymph nodes		
Heart (note murmur if present)		
Pulses		
Lungs		
Abdomen		
Skin		
Musculoskeletal		
Neck		
Spine/Scoliosis		

__ Cleared for participation without restrictions

__ Cleared after completing evaluation and/or rehabilitation for:

_____

__ Not cleared for: _____
Reason: _____
Recommendations:_____

111 North Dewey St. Suit A North Platte, NE

Phone: (308)696-1201 Date: July 22, 2019

_____
(Signature of Medical Provider)

PHAB Accredited Health Department – Public Health Accreditation Board – Advancing public health performance

WEST CENTRAL DISTRICT HEALTH DEPARTMENT
Lincoln, Logan, McPherson, Thomas, Hooker, & Arthur Counties

Dental Screening Report Card

Child's Name_____

Dear Parent or Guardian,

Your child has received a dental screening at school today. Your child is assessed according to the following categories:

Screening Categories		
0	**1**	**2**
no obvious problems of the teeth. Regular dental care is encouraged.	observable problems with the teeth in one or two areas (quadrants). Parents are notified of need for further dental care.	Observable problems with the teeth in three or more areas (quadrants) or urgent needs such as pain, swelling, abscesses or drainage. Parents notified of urgent need for further dental care.

The results of the screening are:
(Check all that apply)

____ Your child has no obvious dental problems.

____ Your child should be evaluated for preventive care (cleaning) or sealants at their next routine visit.

____ Your child appears to have some dental problems which should be evaluated by a dentist.

Dental problems observed in: ____ Right Upper Quadrant ____ Left upper quadrant

____Right Lower quadrant ____Left upper quadrant.

____ Your child appears to have an URGENT dental need. Please make an appointment at your earliest convenience so that your child can receive a complete examination. Your dentist will determine, what, if any, treatment is needed.

Dental problems observed in: ____ Right Upper Quadrant ____ Left upper quadrant

____Right Lower quadrant ____Left upper quadrant.

A screening is not a comprehensive clinical examination. No x-rays were taken and the screening does not replace an in-office dental examination by your family dentist. All children need to have regular routine care by a dental professional.

Additional Comments:

Parent: Please take this referral to the dentist if it is recommended above.

_____ _____

Screener Per NE statute:7-005.01C, 7-005.01C2 Date

WEST CENTRAL DISTRICT HEALTH DEPARTMENT
Lincoln, Logan, McPherson, Thomas, Hooker, & Arthur Counties

STAFF USE ONLY
TIME IN:
TIME OUT:

PATIENT ENCOUNTER **(CHILD)**

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	MEDICAL PROVIDER
GENDER	RACE	SCHOOL	SOCIAL SECURITY #		MOTHER'S MAIDEN NAME
ADDRESS		CITY	STATE	ZIP	COUNTY TELEPHONE #

Please answer the questions below about your child:

ANY HEALTH PROBLEMS? _____

DIAGNOSED WITH ASTHMA? TAKING A STEROID? _____

CURRENT MEDICATIONS: _____

ANY PREVIOUS REACTIONS TO VACCINES? YES NO ALLERGIES: _____

HOW DID YOU HEAR ABOUT OUR SERVICES HERE AT WCDHD? **(PLEASE CIRCLE ALL THAT APPLY)**
Radio TV Billboard Physician Friend/Family Postcard Facebook WCDHD WAITING-ROOM
Other:_____Please Specify

By initialing below, I am consenting for the following vaccines:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DOES THE CHILD VISIT A DENTIST REGULARLY? YES NO DATE OF LAST DENTAL VISIT _____

WHEN WAS THE CHILD'S LAST WELL CHILD'S EXAM/PHYSICAL? _____

PARENT/GUARDIAN INFORMATION (Insured party if applicable)

LAST NAME	FIRST NAME	MI	BIRTHDATE	SS#
ADDRESS	STATE	ZIP	TELEPHONE#	
EMPLOYER	ADDRESS		STATE	ZIP TELEPHONE#

CELLULAR PHONE, TEXT, PHOTO, AND EMAIL CONTACT POLICY: By providing WCDHD with an email address or telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications - including but not limited to prerecorded or artificial voice message calls, text messages, emails and calls made by an automatic telephone dialing system - from us and our affiliates and agents at that number. This express consent applies to each such email and telephone number that you provide to us now or in the future and permits such calls, texts, and emails regardless of their purpose. Calls and messages may incur access fees from your cellular provider. From time to time WCDHD takes photos or video of our programs to use in our marketing materials both in print and on the web. By signing this form, you're giving consent to have your photo used for these purposes. If you do not agree to have your photo used, please call WCDHD and we will make arrangements to exclude your photo from use.

HIPAA: By signing this form, I understand the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly; obtain payment from third-party payers; conduct normal healthcare operations such as quality assessments and physician certifications and that my protected health information may be entered into state or national registries, access to which is restricted to persons who have signed agreements to keep all patient registry information confidential. I have been informed by you and your Notice of Privacy Practices containing a more complete description the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

By signing below, I acknowledge: *The above information is true to the best of my knowledge. I have been educated on the vaccines and I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of vaccination and ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize WCDHD to release immunization records to the medical provider and school listed above. I am aware that if my insurance does not cover the care received I am financially responsible for the balance.*

PARENT/GUARDIAN SIGNATURE	RELATIONSHIP TO CHILD	DATE

VACCINE	VIS DATE	VIS GIVEN	AGE	CPT CODE	EXP DATE	LOT NUMBER	SITE	NURSE SIGNATURE/DATE & TIME
DTaP *INFANRIX*	08/24/18		6WKS-7YRS	90700				
DTaP/HBV/POLIO *PEDIARIX*	08/24/18 10/12/18 07/20/16		6WKS-6YRS	90723				
DTaP/HIB/POLIO *PENTACEL*	08/24/18 04/02/15 07/20/16		6WKS-4YRS	90698				
DTaP/Polio *KINRIX*	08/24/18 11/08/11		4Y-6Y	90696				
FLUBLOK Pre-Filled Syringe	8/07/15		18y-64y	90673				
FLULAVAL .5 ML Pre-Filled Syringe	8/07/15		6M+	90686				
FLULAVAL .5 ML MULTIDOSE VIAL	8/07/15		6M+	90688				
HEP A *HAVRIX*	7/20/16		1YR+	90633				
HEP B *ENGERIX*	10/12/18		BIRTH+	90744				
HEP A & HEP B *TWINRIX*	7/20/16 10/12/18		18Y +	90636				
HIB *ACTHIB*	4/2/15		2M-59M	90648				
HPV 9 *GARDASIL*	12/02/16		9Y-26Y	90651				
JAPANESSE ENCEPHALITIS *IXIARO*	1/24/14		17Y +	90738				
MENINGOCOCCAL *MENVEO*	08/24/18		2YRS-55YRS	90734				
MEN B *BEXSERO*	08/09/16		10YRS – 25YRS	90620				
MMR II (SQ)	2/12/18		1YR+	90707				
PNEUMO *PREVNAR 13*	11/5/15		6WKS-5YRS	90670				
POLIO *IPOL (IM OR SQ)*	7/20/16		6WKS+	90713				
ROTAVIRUS *ROTATEQ (PO)*	2/23/18		6WKS-35WKS	90680				
Td *TENIVAC*	2/24/14		7YRS+	90714				
Tdap *ADACEL/BOOSTRIX*	2/24/15		10YRS+	90715				
VARICELLA *VARIVAX (SQ)*	2/12/18		12 M-55YRS	90716				
YELLOW FEVER *YF-VAX (SQ)*	3/30/11		9M+	90717				
TYPHOID *TYPHIM VI*	5/29/12		2YRS+	90691				
RABIES *IMOVAX*	10/06/09		INF-ADT	90675				
Allergy Shots 1 SHOT 2+ SHOTS				 95115 95117				
OTHER VACCINES:								