Name of Clinic or Office

Address

Phone/Fax Numbers

Physical Examination (to be completed by physician or designee)

Child's Full Name:_____

Address:_____

Age:_____ **Height:**_____**Weight:**_____

Skin:_____ **Head & Scalp:**_____

Eyes:_____ **Nose:**_____ **Lymph Nodes:**_____

Ears:_____ **(L) TM**_____ **(R) TM:**_____

Mouth: Teeth:_____ **Gingiva:**_____ **Palate:**_____

Throat:_____ **Neck:**_____ **Chest:**_____

Heart_____ **B.P.**_____ **Femoral Pulse**_____

Lungs_____ **Abdomen**_____

Genitalia_____ **Rectum, Anus**_____

Spine and Back_____ **Extremities**_____

Neuromuscular_____ **Gait**_____

Urinalysis_____

Vision: (R) eye_____ **(L) eye**_____ **Both**_____

Hearing: Normal_____ **Abnormal**_____ **Not Tested**_____

If needed: Hemoglobin or Hematocrit_____ **Tuberculin Screening**_____

Sickle Cell Screening_____ **Development Testing**_____

Lead Screening_____ **Other**_____

Allergies_____

Summary of findings and recommendations: I have examined_____

He/she is ____☐____ is not____☐____ physically and emotionally able to participate in your program.

Additional Comments:

Date of physical examination_____

_____
Signature of Physician or Designee

_____
Date

PARENT: Please complete the following:

Diseases child has had:

Any special health needs (susceptible to colds, recurrent ear infections, etc.)

Please turn in to: Keota Elementary School
P.O. Box 88
Keota, Iowa 52248
Phone (641)636-2323
Fax (641)636-3009