
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