

EAST ELEMENTARY
501 NORMAL COLLEGE AVENUE
SHELDON, IA 51201
PHONE: 712-324-4437 FAX: 712-324-4338

Remember...
Your child's **signed immunization record** is required in addition to this signed form.



CHILD PHYSICAL EXAMINATION FORM

This form is to be completed by a physician or physician designee.

First Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Sex Male Female

Age _____ Height _____ Weight _____

Skin _____ Head & Scalp _____

Left Eye _____ Right Eye _____

Left Ear _____ Right Ear _____

Nose _____ Lymph Nodes _____

Mouth _____ Palate _____

Teeth _____ Gingiva _____

Throat _____ Neck _____

Chest _____ Heart _____

Blood Pressure _____ Femoral Pulse _____

Lungs _____ Abdomen _____

Genitalia _____ Rectum, Anus _____

Spine and Back _____ Extremities _____

Neuromuscular _____ Gait _____

Urinalysis _____ Allergies _____

Vision _____ Hearing _____

ADDITIONAL INFORMATION, AS NEEDED

WNL:

Vison Screening Y or N

Dental Screening Y or N

Lead Screening _____ Other _____

EXAM RESULTS

After examining this child, I have determined that he/she is physically and mentally able to attend and be cared for in a group child care facility.

Signature of Physician/Designee _____ Date _____

If unable to attend, please provide an explanation below.

