See Reverse Side

Coon Rapids-Bayard Pre K-Head Start-Kindergarten Physical

Child's Name _____ Date of Birth _____

Height _____ Weight _____ B/P _____

HGB _____ Lead Screen_____ Vision (R/L) _____

Please **circle** and explain if child has a history of any of the following:

Asthma	ADHD	Frequent Ear Infections	Myringotomy
Seizures	Tonsillectomy	Eczema	Chicken Pox

_____

_____

_____

_____

Allergies: _____

Routine Medications: _____

Illness/ Injury: _____

Hospitalizations/ Surgeries: _____

Any health conditions requiring intervention/ modification at school:

_____

_____

_____

List any immunizations given today: _____

PLEASE RETURN FORM TO COON RAPIDS-BAYARD SCHOOL NURSE
905 North Street Coon Rapids, IA 50058
Fax Number: 712-999-7740

See Reverse Side

Assessment	WNL/Abnormal/ Referred	Comments
General Appearance		
Ear, Nose, Throat		
Chest, Heart, Lungs		
Abdomen		
Skin		
Bones, Joints, Muscles		
Motor Skills		
Dental Screen		

Examined By: _____ Provider Signature_____

Phone Number _____ Clinic Name _____ Date _____

Parent/ Guardian Signature _____

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