



715 College Street Cedar Falls, Iowa
Phone: 319/268-0165

PHYSICAL EXAMINATION

(To be completed by a physician or designee)

Child's Full Name: _____ Birth date: _____

Address: _____ Phone #: _____

Age: _____ Height: _____ Weight: _____ Skin: _____

Head and Scalp: _____ Eyes: _____ Nose: _____ Lymph Nodes: _____

Mouth: _____ Teeth: _____ Gingiva: _____ Throat: _____ Neck: _____

Chest: _____ Heart: _____ B.P. _____ Femoral Pulse: _____ Lungs: _____

Abdomen: _____ Genitalia: _____ Rectum, Anus: _____ Spine and Back: _____

Extremities: _____ Neuromuscular: _____ Gait: _____

Vision: (R) _____ (L) _____ 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 the physical examination: _____

Signature of the Physician or Designee Date

Print Name of Physician or Designee Clinic or Office Address

**A signed immunization record must accompany this form. Please ask your doctor for a current copy.