St. Athanasius
641 Stevens Street
Jesup, Iowa 50648
PHYSICAL EXAMINATION FORM

Physician:_____
Facility:_____
Address:_____
Child's Full Name:_____
Address:_____

Physical Examination (to be completed by physician or designee)

Age_____Height_____Weight_____
Skin_____
Eye_____Nose_____
Ears_____(L) TM_____
Mouth: Teeth_____Gingiva_____
Throat_____Neck_____
Heart_____
Lungs_____
Genitalia_____
Spine and Back_____
Neuromuscular_____
Vision: (R) eye_____(L) eye_____Both_____
Hearing: Normal_____Abnormal_____Not Tested_____
If needed *Hemoglobin or Hematocrit*_____
*Sickle Cell Screenin*_____
*Lead Screening*_____

Urinalysis_____
Head and Scalp_____
Lymph Nodes_____
(R) TM_____
Palate_____
Chest_____
B.P._____Femoral Pulse_____
Abdomen_____
Rectum, Anus_____
Extremeties_____
Gait_____
*Tuberculing Screening*_____
*Development Testing*_____
*Other*_____

Allergies_____

Summary of findings and recommendations: I have examined (*name of child)*_____
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.)_____
_____