Messiah Preschool ♦ 2411 West Avenue ♦ Burlington, Iowa 52601 ♦ 754-7591 ext. 2

**Physical Examination**

(to be completed by physician or designee)

Child's Full Name _____ Date of Exam _____

Address _____

Age _____ Birth date _____ Height _____ Weight _____

Skin _____ Head & Scalp _____ Lymph Nodes _____ Ears _____ Eyes Tested _____

Mouth: Teeth _____ Gingival _____ Palate _____ Date of Last Dental Exam _____

Throat _____ Tonsils _____ Tonsillectomy date _____ Neck _____

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

Lungs _____ Abdomen _____ Genitalia _____ Rectum, Anus _____ Urinalysis _____

Spine and Back _____ Extremities _____ Neuromuscular _____ Gait _____

Hearing: Normal _____ Abnormal _____ Not tested _____

Allergies _____

Asthma _____ Indicate treatment to administer if necessary _____

*Lead screening results _____ Other _____
(required for preschool file)

If needed: Hemoglobin or Hematocrit _____ Tuberculin screening _____

Sickle Cell screening _____ Development testing _____

History of : Hay fever ____ Ear infections ____ Influenza ____ Colds ____ Strep throat _____

Operations: _____

Summary of finding and recommendations: I have examined _____
_____ (Child's Name)

He/She is _____ is not _____ physically and emotionally able to participate in your program.

Additional comments: _____

_____

_____ _____
Signature of Physician or Designee Street Address

Phone _____

REV. 2020