



Newton Community School District Elementary Physical Form

Student Name _____ Date of Birth _____

Parent/Guardian _____

Family Physician _____

Date of Visit _____ Blood Pressure _____

Height _____ Weight _____

Temp _____ Pulse _____ Respiration _____

Allergies:

Food, please be specific _____

Medications, please be specific _____

Environmental, please be specific _____

Do any of the above require treatment with emergency medication? _____

If so, please specify what symptoms are to be treated: _____

Medication _____ Dose _____ Frequency _____

Current Medication:

Prescriptions _____

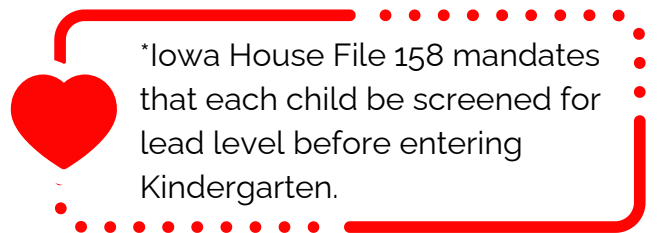
Over the Counter _____

Diagnosis:

Has this child been tested for lead? Yes No

Date of screening _____

Result of screening _____





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Visual Acuity:

Right Eye _____ Left Eye _____ Referral to Eye Dr: Yes No

Dental Condition:

- No obvious problems Requires urgent dental care
 Requires dental care Referral made to dentist

Physical Exam:

General Appearance _____
Nutrition _____
Skin _____
Eyes _____
Ears _____
Nose/Throat _____
Heart/Lungs _____
Abdomen _____
Extremities _____
Developmental Screening _____

Any other significant health history, including surgeries, injuries, etc:

Can this child participate in physical education class or recess without limitations?

Yes No, please explain _____

Examining Physician _____

Date _____

Newton Community School District
Attention Melinda Robertson
1302 1st Ave W
Newton, Iowa 50208
Phone 641.792.5809, Option 2 | Fax 844.494.8063