

Sidney Elementary School
Physical Form Fax 712-374-2648

Child's Name: _____ DOB: _____ Age: _____ Sex: M F

Allergies: _____ Medications: _____

Dentist Name: _____ Location: _____

Required by law:

Hgb/Hct: _____ Fluoride application: YES NO Dental Screen: YES NO Referral Made: YES NO

Lead Level: _____ ug/dl Date Drawn: _____ Ht: _____ Wt: _____ B/P: _____ Pulse: _____

Vision: Right eye _____ Left eye _____ Hearing: Right ear _____ Left ear _____

Required by School:

Does examination reveal any abnormality in:	Normal for Age	Abnormal	Not examined	Comments
HEENT				
Teeth				
Heart				
Lungs				
Stomach/Abdomen				
Genitalia				
Bones, Joints, Muscles				
Muscular Coordination				
Skin, Lymph Nodes				
Neurological				
Gait				
Speech				
Behavior				
General appearance				

Developmental referral made: YES NO Immunizations: **Please attach a complete record and return to school**

Immunizations given today _____

Insurance Type: _____ Medicaid (Title 19) # _____ hawk-I _____

Physician: _____ Location: _____ Phone: _____

 Date: _____

(Physician Signature)

(Date of Exam)