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)**