

Muscatine Community School District School Entrance Physical Examination

_____ has had a complete history and physical exam on _____

Student's Name Birth Date Month/Day/Year

Screening/Test Results	
Height:	
Weight:	
BMI:	
Blood Pressure:	
Pulse:	
Urinalysis:	
Lead: (Date/Result)	
Gross Dental:	
Other: (List/Result)	

Physical Exam	
General Appearance:	<input type="checkbox"/> Healthy <input type="checkbox"/> Other _____
Nutrition:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
E.E.N.T.:	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____
Heart & Lungs:	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____
Posture:	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____
Tonsils & Glands:	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____
Abdomen:	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____
Other: (List/Result)	

TB: In high-risk group? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Test	Date	Results

Physical Exam Comments:

Vision Screening? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Without glasses		<input type="checkbox"/> With glasses	
Distance	Near		
R 20/ L 20/	R 20/ L 20/		

Operations or injuries? (If yes, please list) <input type="checkbox"/> Yes <input type="checkbox"/> No

Auditory Screening? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Right: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	
Left: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	

Allergies? (If yes, please list) <input type="checkbox"/> Yes <input type="checkbox"/> No

This student has the following problems which may adversely affect his or her educational experience:

Vision
 Auditory
 Speech/Language
 Physical Dysfunction
 Emotional/Social
 Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, asthma, allergies, anaphylaxis. *Specify below.*

The pupil is on long-term medication. *Specify below.*

Comments and recommendations (additional information about any of the above health assessment): _____

This student may participate fully in the school program, including physical education activities.

This student may participate in the school program and physical education with the following restriction/adaptation: *(Specify reason and restriction/adaptation)* _____

Signature of health care provider	Name/Group Practice (Please type or print)	Phone Number
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