WAUKEE COMMUNITY SCHOOL DISTRICT

PHYSICAL REPORT

Student Name	
Birthdate	
Parent/Guardian Name	
Street Address	
City	
State/Zip	
School of Attendance	

SIGNIFICANT HEALTH HISTORY

Yes	No		Comments
		Asthma	
		Seizures	
		Diabetes	
		Heart Disorder	
		Pneumonia	
		Rheumatic Fever	
		Scarlet Fever	
		Eczema	
		Meningitis	
		Chicken Pox	
		Other	

HEALTH INFORMATION

Weight	
Height	
Blood Pressure	
Hemoglobin	
Urinalysis	
Hearing Screening	**Referral** (circle one) Yes No
Blood Lead Level STATE REQUIRED KINDERGARTEN	Date Completed_____ Level _____
Vision Screening STATE REQUIRED KINDERGARTEN/9THGRADE	**R 20/ L 20/ Both 20/** **Referral** (circle one) Yes No

PHYSICAL EXAMINATION

X= Normal or Negative		Comments
	Appearance	
	Posture	
	Nutrition	
	Neurological	
	Speech Defect	
	Hair and Scalp	
	Nose	
	Ears	
	Throat	
	Thyroid	
	Lymph Nodes	
	Heart	
	Lungs	
	Extremities	
	Abdomen	
	Skin	
	Hernia	
	Back	
	Neurological Evaluation	

PHYSICIAN COMMENTS/ HEALTH CONCERNS

Allergies
Surgeries
Hospitalizations
Medications
Developmental Screenings/Concerns
Physical Education Restrictions
Health Related Anatomical Restrictions
Special Health Needs / Additional Comments

Examiners Signature Date