CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT
PRESCHOOL PHYSICAL HEALTH EXAM FORM rev.3/2023

A physical exam must be completed by a licensed health care provider for preschool attendance. A licensed physician and surgeon, osteopathic physician and surgeon, osteopath, qualified doctor of chiropractic, advanced registered nurse practitioner, or physician's assistant complete this report.

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

Student Name _____ Birth Date _____

School _____ Sex: M F

Parent/Guardian Name _____ Phone _____

Student Chronic Health Conditions (asthma, diabetes, seizures, sickle cell etc): _____

_____

Student Current Medications: _____

THIS SECTION TO BE COMPLETED BY THE HEALTHCARE PROVIDER

Date of Exam: _____

Height: _____ Weight: _____ **Blood Pressure**:_____

Blood Lead Level: date_____ results _____ **Vision Exam**: Right eye: _____ Left eye:_____

Allergies (food, medicine, insects): _____

Immunization Status _____ up to date _____ deficient _____ catch up schedule

**** Please attach a copy of current immunizations and/or medical waiver ****

	WNL= within normal limits	**Comments**
HEENT		
Oral/Teeth		
Lungs, Heart		
Stomach/Abdomen		
Musculoskeletal		
Skin		
Neurological		
Posture, Gait, Coordination		
Developmental or Behavioral Concerns		

Referrals made today: _____

Health Care Provider Name: _____

Health Care Provider Signature: _____ **Date:** _____