Regina Pre-K, Preschool & Daycare, Early Childhood Center
2140 Rochester Ave., Iowa City, IA 52245
PHYSICAL EXAMINATION FORM

Physician: _____
Facility: _____
Address: _____
Child's Full Name: _____
Address: _____

Physical Examination (to be completed by physician or designee)

Age _____Height _____Weight _____ Urinalysis _____
Skin _____ Head and Scalp _____
Eye_____ Nose_____ Lymph Nodes _____
Ears _____ (L) TM _____ (R) TM _____
Mouth: Teeth_____ Gingiva _____ Palate _____
Throat_____ Neck_____ Chest _____
Heart _____ B.P. _____ Femoral Pulse _____
Lungs _____ Abdomen _____
Genitalia _____ Rectum, Anus _____
Spine and Back _____ Extremities _____
Neuromuscular _____ Gait _____
Vision: (R) eye _____ (L) eye _____ Both _____
Hearing: Normal _____ Abnormal _____ Not Tested _____

If Needed: *Hemoglobin or Hematocrit* _____ *Tuberculin Screening* _____
Sickle Cell screening _____ *Development Testing* _____
Lead Screening _____ *Other* _____
Allergies _____

Summery of findings and recommendations: I have examined *(name of child)* _____
He/She is ____ is not____ physically and emotionally able to participate in your program.
Additional Comments: _____
_____
Date of the physical examination: _____

_____
Signature of Physician or Designee

_____
Date

****Parent please complete the following:***
Diseases child has had _____
_____
Any special health needs (susceptible to colds, recurrent ear infections, etc.) _____
_____