Linn-Mar Community Schools

Elementary Student Physical Exam Form

Student Name: _____

Date of Birth: _____

Address: _____

Parent/Guardian: _____ Home Phone: _____

School: _____ Grade: _____ Sex: M F

Parent or Guardian, please answer the following:

Any medical problems or health concerns? No ___ Yes ___
Any hearing, vision or speech problems? No ___ Yes ___
Contact Lenses, glasses or hearing aids? No ___ Yes ___
Any allergies? No ___ Yes ___
Any medications? No ___ Yes ___

Would you consent to exchange of information between school nurse and your healthcare provider regarding student's health status? If so, please sign here.

_____ Date: _____

Physician Recommendation:

Date of Exam: _____ Height: _____ Weight: _____ Hgb: _____

BP: _____ Pulse: _____ Vision: _____ Lead: _____

1. Is there any significant health history? Chronic illness, surgeries, injuries, etc? No ____ Yes _____
2. Is this student subject to any condition which may result in a classroom emergency or limit participation during the school day – Diabetes, asthma, allergies, seizures, cardiac? No ____ Yes _____
3. Student immunizations are up to date? No ____ Yes _____
4. Immunizations given today? _____
5. Updated TDAP for 7th grade? _____
6. Student can participate in all school activities? No ____ Yes _____

I have interviewed and examined this student: Physician Name, Address and Phone (print)

Name _____ Phone _____

Address _____

Physician Signature _____ Date _____

Revised 10/15