Estherville Lincoln Central School District
Estherville, Iowa 51334
Ph. 712-362-8402 Fax. 712-362-7842

Student _____

Female **Male** **Date of birth** _____

Medical and Health History

History	Date	Comments	
Prenatal/Birth			
Allergies		To Medication_____ To Food_____ To Latex_____ **Epi-pen** ❑ Yes ❑No	
Asthma			
Medications			
Illness, serious			
Chickenpox		○ Diagnosed	○ By report
Injury, serious			
Hospitalization/ Surgery			
Immunizations **Attach IRIS form**	○ Up to date for school entry ○ Boosters needed:		
Other (disabilities, diseases or disorders)			

Physical Exam and Assessment
By Physician, Nurse Practitioner or Physician Assistant

Date of exam: _____

Height _____ Weight _____ Blood pressure _____

Vision: Both 20/____ Right 20/_____ Left 20/_____

System	WNL	Comments
Skin		
Eyes		Referred?
Ears/Hearing		
Mouth		
Speech		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Spinal		**Scoliosis Screening** WNL____ Referred____
Neurologic		
Emotional/social		
Lead screening (required)		**Date:** **Results:**
Dental screening (required):		**Referred? State Dental Form Required**
Labs if indicated		
TB risk		Mantoux if indicated

Health conditions requiring intervention/modification at school:

Physical Education Program: Full_____ Limited_____ None_____
Reason:

Examined by (print) _____

Signature _____ **Date** _____

Clinic _____ **Phone** _____