EARLY CHILDHOOD PROGRAMS
PHYSICAL EXAM—Birth to 5 years

Name: _____ Gender: _____ Birthdate: _____
Parent/Legal Guardian Name: _____ Phone _____
Physician's Name: _____ Phone _____ Fax _____
Allergies: Foods _____ (Physician must complete and sign Food Substitution Request)
Medications _____ **Other** _____
Immunizations: Attach Iowa Certificate of Immunizations (must be up-to-date for age)

Physical Assessment:

	Normal (X)	Abnormal (X)	Comments (required for Abnormal)
Skin			
Hair & Scalp			
Eyes			
Ears			
Nose/Throat			
Mouth/Teeth			
Lymph Nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Neurological			
Musculoskeletal			
Endocrine			
Abdomen			
Nutrition			
Appearance			
Development			
Other			

Required:
Hgb or Hct _____/Date _____ Lead _____/Date _____ TB test _____/Date _____
If lived in or visited foreign country in past 12 mo.
Height _____ Weight _____ Head Circumference _____ Birth to 2 years **Blood Pressure _____** Age 3 years and up

Activity Restrictions: _____
Conditions that might affect school performance: _____

Licensed Health Care Provider Signature _____
Exam Date_____ Clinic Name: _____Address: _____

I hereby authorize my child's health care providers to release to Des Moines Public Schools Early Childhood Programs and exchange between each other information contained in the clinical records of _____. Redisclosure to any 3rd parties is prohibited without my written consent.

_____/_____ _____/_____
Signature of Parent/Legal Guardian Date Signature of Witness Date

_____/_____
Signature of Parent/Legal Guardian Date

Rev. 2/2007