CHILD PHYSICAL EXAMINATION

LilyPad Learning Center
600 E 1st Street
Huxley, IA 50124
(515) 597-5437
(515) 597-5438 (fax)

Child's Full Name ______________________ **Birth Date** ______________

Health Assessment

Date of physical examination ______________________

1. Height ________ Weight ________
2. BP ______________
3. Eyes R________ L________
4. Ears R________ L________
5. Nose ______________
6. Throat ______________
7. Speech ______________
8. Heart ______________
9. Lungs ______________
10. Abdomen ______________
11. Genitals ______________
12. Orthopedic ______________
13. CNS ______________
14. Muscular ______________
15. Teeth ______________
16. Allergies ______________
17. HgB ______________
18. UA ______________
19. TB Test ______________
20. Child on medications?

    Yes ________ No ________

    If yes, what? ______________

    ____

    ____

    ____
21. Child suffers with chronic disease?

    ____

    ____

    ____

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Health Provider Assessment Statement

☐ The child may participate in developmentally appropriate child care/preschool with ***no restrictions.***

☐ The child may participate in developmentally appropriate child care/preschool ***with the following restrictions:***

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The State of Iowa requires all children attending school to be immunized against Diptheria, Pertussis, Tetanus, Polio, Measles and Rubella. ***Please include an updated and signed Certificate of Immunization.***

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MD/DO/PA/ARNP Signature **Date**