Urbandale Community School District
Physical Examination

To be completed by physician

Student's Name	Birthdate M/ F
Parent's Name	Phone
Physician's Name	Phone

	Comments		Comments
Allergies: Food		Diabetes	
Allergies: Medicine		Hospitalization	
Allergies: Other		Illnesses	
Asthma		Injuries	
Bleeding Problems		Seizures	
Cancer		Surgery	

Height	Weight	BP	Hemoglobin	Lead Screen	Vision (Right)	Vision (left)	Corrective Lenses	Hearing
					20/	20/		

	Normal (✓)	Abnormal (✓)	Comments (required for abnormal)
Skin			
Hair & Scalp			
Eyes			
Ears			
Nose			
Mouth / Dental			
Lymph nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Neurological			
Musculoskeletal			
Endocrine			
Spinal Examination			
Nutritional Status			
General Appearance			
Developmental			
Other			

Medications _____

Activity Restrictions _____

Conditions that might affect school performance _____

*****IMMUNIZATION CARD MUST BE ATTACHED TO THIS PHYSICAL*****

Physician's Signature _____ **Date** _____