DES MOINES PUBLIC SCHOOLS EARLY CHILDHOOD
PHYSICAL EXAM

Student Name ____**Gender** __________ **Birthdate** _________________

Parent/Legal Guardian Name ____

Physician's Name _____________________________________ **Phone** ___________________ **Fax** _________________

Allergies: Foods _______________________________ **Physician must complete and sign DMPS Diet Modification Form!*

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			
NEURLOGICAL			
MUSCULOSKELETAL			
ENDOCRINE			
ABDOMEN			
NUTRITION			
APPEARANCE			
DEVELOPMENT			
OTHER			

REQUIRED FOR ALL STUDENTS

LAB RESULTS FROM ANY EXAM: Hgb or Hct _______ & Date _______ Lead _______ & Date _______

VITALS FROM TODAY'S EXAM: Height _______ Weight _______ Blood Pressure _______

ATTENTION PROVIDER: A TB test is required if this student is found to be at high risk: TB Test _______& Date _______

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 ____________________(student's name). Redisclosure to any 3rd Parties is prohibited without my written consent.

Parent/Legal Guardian Signature ____ Date____________________

05/2023