DAVENPORT Community Schools
GROWING EXCELLENCE

CHILD'S Name:_____ Birth date: _____ (Circle) Male/Female

Parent's Name_____
Address:_____

Current Medications: (please include over the counter, vitamins and homeopathic)

_____

_____

ALLERGIES: (includes medication, foods, environmental)_____

| | Result | Remarks |
|---|---|---|
| Height | | |
| Weight | | |
| Vision<br>Right Eye<br>Left Eye | | |
| Blood Pressure | | |
| Lead Screen (REQUIRED) | | |
| Hemoglobin/Hct (if needed) | | |
| Urinalysis (if able to obtain) | | |
| Tuberculin (if applicable) | | |
| Hearing (if needed) | | |

| Physical Examination/Assessment | Normal For Age | Abnormal For Age | Not Evaluated | Remarks |
|---|---|---|---|---|
| General Appearance | | | | |
| Posture/Gait | | | | |
| Speech | | | | |
| Head | | | | |
| Skin | | | | |
| Eyes: (1) External aspects<br>(2) Optic Fundiscopic | | | | |
| Ears (1) External and Canals | | | | |
| (2) Tympanic Membranes | | | | |
| Nose, Mouth, Pharynx | | | | |
| Teeth | | | | |
| Heart | | | | |
| Lungs | | | | |
| Abdomen | | | | |
| Bones, Joints, Muscles | | | | |
| Neurological/Social | | | | |
| Gland (Lymphatic/Thyroid) | | | | |
| Muscular Coordination | | | | |

Specific Recommendations (physical education, Etc)_____

Existing Health Problems:_____

Health Provider's Printed Name:_____ Telephone number:_____

**HEALTH PROVIDERS SIGNATURE**:_____ **EXAM DATE**:_____

NURSE – Physical form