Physical Exam and Assessment
By Physician, Nurse Practitioner or Physician Assistant

Southeast Polk Community School District
8379 NE University Ave., Pleasant Hill, Iowa 50327
Ph. Fax.

Student ____

Female **Male** **Date of birth** ________________

Medical and Health History

History	Date	Comments	
Prenatal/Birth			
Allergies		To Medication___________________ To Food__________________ To Latex_____ **Epi-pen** ❑ Yes ❑No	
Asthma			
Medications			
Illness, serious			
Chickenpox		○ Diagnosed	○ By report
Injury, serious			
Hospitalization/ Surgery			
Immunizations **Attach IRIS form**	○ Up to date for school entry ○ Boosters needed:		
Other			

Height ________ Weight __________ Blood pressure ____________

Vision: Both 20/____ Right 20/_____ Left 20/_______

System	WNL	Comments
Skin		
Eyes		Referred?
Ears/Hearing		
Mouth		
Speech		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Spinal		**Scoliosis Screening** WNL____ Referred____
Neurologic		
Emotional/social		
Lead screening (required)		**Date:** **Results:**
Dental screening (required):		**Referred? State Dental Form Required**
Labs if indicated		
TB risk		Mantoux if indicated
Health conditions requiring intervention/modification at school:		
Physical Education Program: Full______ Limited_______ None______ **Reason:**		

Examined by (print) ______________________ **Clinic name** _________________________ **Phone number** _________________________

Signature ____ **Date** ____________

Physician