Physical Exam and Assessment
Preschool/ Kindergarten
By Physician, Nurse Practitioner or Physician Assistant

Red Oak Community Schools
Inman Primary School
2011 N. 8th Street
Red Oak, IA 51566
Phone: 712-623-6635 Fax: 712-623-6638

Student _____
Female_____ **Male**_____ **Date of Birth**_____

Medical and Health History

History	Date	Comments
Allergies: **(All Food Allergies will require a Dietary Modification Form)**		To Medication:_____ To Foods:_____ To Latex:_____ **Epi-pen**: Yes_____ No_____ **Please include allergy Plan**
Asthma: **Please include Asthma Plan from Doctor**		
Medications:		
Illness, 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		
Ears/Hearing		
Mouth		
Speech		
Neck		
Heart		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurologic		
Emotional/social		
Lead screening **(required)**		Date: _____ Results:
Dental screening **(required)**		State Dental Form Required
Labs if indicated		

Health conditions requiring intervention/modification at school:

Physical Education Program: Full_____ **Limited**_____ **None**_____
Reason:

Examined by (print) _____ **Clinic name:** _____ **Phone:** _____

Signature _____ **Date:** _____ **Parent/Guardian**_____
Physician