St. Patrick School
615 Washington Street
Cedar Falls, Iowa 50613

Phone: 319-277-6781
Fax: 319-266-5806

Kindergarten Physical

Name _____ Birth Date _____
Last First Middle
Address _____ Phone _____

_____

History of serious illness: _____

Injuries and surgeries: _____

Allergies: _____

_____

✔ = Normal (or Describe Impairment)

_____ Eyes
_____ Ears
_____ Nose
_____ Throat
_____ Lungs
_____ Neurological
_____ Hgb
_____ Heart
_____ Abdomen
_____ Hernia
_____ Genitalia
_____ Orthopedic
_____ Urinalysis

Blood Pressure _____ Height _____ Weight _____

Heart Rate: Before Exercise _____ After Exercise _____

Scoliosis: Yes No_____

General Physical Condition: _____ Excellent _____ Good _____ Fair _____ Below Average

Describe any impairments: _____

Do you recommend a referral? Yes No If yes, what kind? _____

_____

Physician's Report

I hereby certify that _____ was examined by me and found physically fit to engage in all physical education classes and school activities.

Restrictions: Why?

Duration: _____

What activities may he/she not take part?

Physician's Signature_____ Office phone_____

Date_____