



Examination by Physician

PLEASE RETURN TO THE SCHOOL:

Name _____ Grade _____ Date _____

General Appearance:
Posture:
Nutrition:
Skin:
Eyes & Ears:
Nose & Throat:
Tonsils & Glands:
Heart:
Lungs:
Abdomen:
Feet:
Urinalysis:
Blood Count:
Lead Screening: Date tested _____ Results _____
What critical illnesses has the child had? Comments:

- Please attach a completed Immunization Certificate

RECOMMENDATIONS: _____

Signature of Physician _____