



PHYSICAL EXAMINATION (to be completed by a physician or designated person)

Child's Full Name: _____ Age: _____

Address: _____ Height: _____ Weight: _____

Skin: _____ Head & Scalp: _____ Lymph Nodes: _____

Eyes: _____ Nose: _____ Ears: _____ (L)TM _____ (R)TM _____

Mouth: Teeth: _____ Gingival _____ Palate _____ Throat: _____

Neck: _____ Chest: _____ Heart: _____ B.P: _____ Femoral Pulse _____

Lungs: _____ Abdomen: _____ Genitalia: _____ Rectum/Anus: _____

Spine & Back: _____ Extremities: _____ Neuromuscular: _____

Gait: _____ Urinalysis: _____

Vision: (R)Eye: _____ (L) Eye _____ Both _____

Hearing: Normal _____ Abnormal _____ Not tested _____

If Needed: Hemoglobin or Hematocrit _____ Tuberculin Screen _____

Sickle Cell Screen: _____ Development Screen: _____ Lead Screen: _____

Other: _____

Allergies: _____

He/She is _____ not _____ physically and emotionally able to participate in your program.

Additional Comments: _____

Date of Physical Examination _____

Signature of Physician _____

CHARLIE BROWN PRESCHOOL AND CHILD CARE

Washington
700 N. Washington
Mason City
641-423-6029
Fax: 641-423-0174

Lake Town
7 B S 8th
Clear Lake
641-357-7277
Fax: 641-357-2972

West Town
1708 S. Monroe Ave
Mason City
641-424-0065
Fax: 641-421-9405



SCHOOL-AGED HEALTH STATEMENT

For use by children currently enrolled in school

I hereby certify that my child_____ is in good health, had all required immunizations, has no contagious diseases or illnesses, and receives regular health care from

(Name of child's physician)

Known Allergies _____

Current Medications being taken_____

Parent/Guardian Signature_____

Date_____

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