DMCS
DES MOINES CHRISTIAN SCHOOL

Physical Examination Form

To be completed by physician. **IMMUNIZATION CARD MUST BE ATTACHED TO THIS PHYSICAL**

Student's Name	Birthdate
Parent's Name	Phone
Physician's Name	Phone

	Date	Comments		Date	Comments
Food Allergies			Meningitis		
Medicine Allergies			Mono		
Other Allergies			Seizures		
Asthma			Freq. Throat Infections		
Cancer			Surgery		
Chicken Pox			Injuries		
Bleeding Problems			Hospitalization		
Freq. Ear Infections					
Heart Disease					

Height	Weight	BP	Hemoglobin	**Lead Screen**	Vision (right)	Vision (left)	Lenses?	Hearing

	Normal ( )	Abnormal ( )	Comments (required for abnormal)
Skin			
Hair & Scalp			
Eyes			
Ears			
Nose			
Mouth/Dental			
Lymph nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Endocrine			
Spinal Examination			
Nutritional Status			
General Appearance			
Developmental			
Other			

Medications_____

Activity Restrictions_____

Conditions that might affect school performance_____

Physician's Signature_____ Date_____